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Well-being and Health Promotion Template

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Well-being and Health Promotion Template

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This Scholarly Project Paper, submitted by Nichole Arn and Cody Mach in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Signature of Faculty Advisor

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ABSTRACT

Purpose: The purpose of this scholarly project was to develop an occupational therapy intervention template that could be utilized at LaGrave on First. LaGrave on First is a new Housing First facility that opened in Grand Forks, ND during the summer of 2018. Literature reviews regarding occupational therapy and its' role with the homeless population were limited and challenging to find, especially with a Housing First emphasis. Within this scholarly project, the reviewed literature was used to develop an intervention guide that could be implemented in conjunction with other occupational therapy interventions for this population. The interventions were created for Occupational Therapist, at the Altru Healthcare Facility, who are providing services for residents of LaGrave on First.

Methodology: A thorough literature review was completed through the use of multiple databases. The databases utilized included: CINAHL, PubMED, PsycINFO, and the American Journal of Occupational Therapy. While using these databases, key search terms included: homeless, homelessness, occupational therapy, intervention, and needs. Throughout the review of literature the occupational therapy students obtained statistics related to homelessness, factors, and comorbidities associated with homelessness, needs of individuals who are homeless, and occupational therapy's role in intervention with this population.

Results/Conclusion: This scholarly project is unique in that it is the first intervention template for occupational therapy services at LaGrave on First. It is the hope of the authors that the product will assist in providing quality occupational therapy intervention to residents. By doing this, it is hoped that residents will have an increased sense of well-being and health promotion in order to increase occupational participation while gaining control of their lives once again.

CHAPTER 1

Introduction

Individuals who are homeless constitute for approximately 1 in every 1,670 people in the United States and is not a problem that has a quick and fast solution (Homeless World Cup Foundation, 2018). Homelessness is a topic that is often marginalized and disregarded in terms of policies and services made available to help (Zacharias, 2017). Some community-based services exist that provide therapy to individuals, but these services often lack the ability to address the unique needs of an individual who is homeless (The Homeless Hub, 2015; Zacharias, 2017). Individuals who are homeless have comorbidities with physical ailments and mental illness that contributes to a decrease in quality of life (The Homeless Hub, 2015; Davis, 2011).

Chronic homelessness has higher rates of chronic stress related to deterioration of physical and mental health (Davis, 2011; Pickett-Schenk, Cook, Grey, Banghart, Rosenheck and Randolph, 2002). Chronic stress for this population, is related to factors of: securing housing, locating food, social interaction with stigma, fear for safety, and substance-use (Fichter & Quadflieg, 2006; Pickett-Schenk et al., 2002). The factors causing stress, are the same factors contributing to the development of mental illness. The homeless population have high rates of major depressive disorder, post-traumatic stress disorder (PTSD), anxiety disorders, and personality disorders (Pickett-Schenk et al., 2002). The

increase in comorbidities leads to the increased need for services to be provided to this population.

Housing First is one service that has been created to address the unique need of the homeless population (Stoffel, 2011). Housing First is a supported housing option that provides immediate housing to individuals (Thomas, Gray & McGinty, 2010), to meet the basic need for shelter. After placement into housing, individuals are then able to remediate skills and occupations (Thomas, Gray & McGinty, 2017). This scholarly project was developed to address the needs of a housing first project that was recently established in Grand Forks, ND.

LaGrave on First (referred to throughout the scholarly project as, LaGrave) is a Housing First facility that provides the homeless population with supportive housing in Grand Forks, ND. In collaboration, Rhonda Roed, OTR/L and the authors developed a product to serve as a template for occupational therapy service implementation within LaGrave.

The product was developed to be evidence-based, client-centered and unique to LaGrave to address the needs of the residents within. The sections of this template are organized with consideration to the Ecology of Human Performance (EHP) model. EHP is the theoretical model that provided the framework for the guide development, and guides the model for occupational therapy service delivery. EHP considers the contextual environment in which occupations occur, and the influence that it has on performance (Brown, 2011; Cole & Tufano, 2008). With residents being new to LaGrave and having contextual changes in their lives affecting occupational performance, this was the

justification for the use of EHP (Brown, 2014; Cole & Tufano, 2008). EHP's contextual influence is also incorporated into the development of interventions in the product.

Interventions included in the product are aimed at developing or re-establishing occupational performance in areas of occupation structured from the Occupational Therapy Practice Framework (OTPF) (AOTA, 2014). The OTPF lays out six areas of occupation: 1. Activities of daily living (ADL's), 2. Instrumental activities of daily living (IADL's), 3. Leisure, 4. Work, 5. Education, and 6. Sleep. The homeless population has needs in all categories of occupation, and this Template was created with consideration towards those needs. The Template is user friendly and has application sections throughout to assist the therapist with implementation.

Terminology

Terminology relevant to this scholarly project are as follows:

- Assessment: A specific tool or instrument that is used to gather data about a client. Can be informal or formal (Brown, 2014).
- Context: An environment in which tasks are completed (Brown, 2014). For this Template, EHP holds basic assumptions that the context is composed of four subcategories including: physical, cultural, social and temporal (Cole & Tufano, 2008).
    - Physical Context: Natural, tangible objects and aspects around an individual (buildings, furniture, tools and devices) (Brown, 2014).
    - Cultural Context: Customs, beliefs, ethnicity, values and/or religious affiliations an individual possess and finds meaningful (Cole & Tufano, 2008).

    - Social Context: Interpersonal relationships among peers, social groups, and social institutions. Social context influences behavior and perceived norms of groups (Brown, 2014).
    - Temporal Context: Duration of time it will take to complete tasks. Considerations for chronological age and lifespan development stage fall into consideration (Cole & Tufano, 2008).
- Evaluation: The process of gathering and interpreting data to better understand influences upon a client's performance (Brown, 2014).
- LaGrave on First: Housing First apartment complex in Grand Forks, ND. Will be referred to simply as "LaGrave" throughout the Template.
- Occupation: Any task or combination of tasks performed in daily life that hold meaning to a person (Brown, 2014).
- Occupational Deprivation: The absence or decreased participation in meaningful occupations (Brown, 2014). Can occur when one is not participating in meaningful occupations by their own choices or limitations; or when contextual barriers exist, then limiting overall participation (Brown, 2014).
- Occupational Performance/ Task Performance: The "doing" of the task (Brown, 2014). All factors of person, task and context coming together to influence actual participation in an occupation (Cole & Tufano, 2008). Performance while participating in an occupation and perception upon how well the occupation was performed (Brown, 2014).
- Person: An individual who performs a task, and the innate abilities that comprise that individual. Abilities are broken down into subcategories including: sensorimotor, cognitive and psychosocial (Brown, 2014; Cole & Tufano, 2008
- Sensorimotor: Physical abilities that an individual possesses (ex. gross/fine motor coordination, physical strength, endurance, etc.) (Cole & Tufano, 2008).

- Cognitive: Mental processes in which an individual utilizes to comprehend and make judgements. (ex. reasoning, problem-solving, executive functioning, etc.) (Cole & Tufano, 2008).
- Psychosocial: Affective and emotional characteristics in which a person utilizes during interpersonal and intrapersonal relationships. (ex. attitude, motivation, open-mindedness, etc.) (Brown, 2014).
    - Interpersonal relationship: Relationships and interactions with other people (Brown, 2014).
    - Intrapersonal relationship: The understanding of and relationship with oneself. (Brown, 2014).
- Task: An activity that is completed by an individual to accomplish a goal (Brown, 2014; Turpin & Iwama, 2011).

This scholarly project is organized into five chapters. Chapter one has been the introduction of the scholarly project. Chapter two consists of a review of literature relevant to the purpose of this scholarly project and information guiding the development of our product. Chapter three is the methodology in which the authors used to complete this scholarly project. Chapter four is a brief narrative of the product developed, with the product in its entirety following the narrative. Chapter five is the summary of this scholarly project.

CHAPTER II

Review of Literature

Introduction

Homelessness is an issue that directly diminishes one's ability to participate in meaningful occupations (Tsang, Davis & Polatajko, 2013). When a person is not able to participate in meaningful occupations their mental well-being and quality of life declines (Stoffel, 2011). The statistics indicate that homelessness and mental illness do correlate 20-25% of the time (Henry, Watt. Rosenthal & Shivji, 2017). Addressing these issues and returning an individual back to meaningful occupations correlates with the objectives of occupational therapy.

Current research points toward Housing First and Supported Housing opportunities as being beneficial to clients who are homeless (Thomas, Gray & McGinty, 2011; Kertesz, Crouch, Milby, Cusimano & Schumaker, 2009). These housing programs provide various services through an interdisciplinary healthcare team including: social work, psychology, recreational therapy, psychiatry, general medicine, case management and more (Thomas, Gray & McGinty, 2017; Lloyd and Bassett, 2012; Fichter & Quadflieg, 2006). The challenge is that occupational therapy is not commonly associated as a part of the interdisciplinary team (Herzberg & Finlayson, 2001).

Current research identifies the beneficial role that occupational therapy can fill when included on an interdisciplinary team (Thomas, Gray & McGinty, 2017; Stoffel, 2011; Fichter & Quadflieg, 2006; VanLeit, Starrett & Crowe, 2006; Herzberg & Finlayson, 2001). Additional research studies have identified the impact that occupational therapy can have when working in mental health practice, specifically, which is often a comorbidity within this population (Fox, 2013; Lloyd & Bassett, 2012; Fuller, 2011; Roy et al., 2007; Griner, 2006; Herzberg, Ray & Miller, 2006; Petrenchik, 2006; VanLeit, Starrett & Crowe, 2006; Finlayson, Baker, Rodman & Herzberg, 2002).

This review of literature was completed for development of a scholarly project, and the following areas are introduced: definitions and statistics regarding homelessness, myths of the population, the experienced needs of the homeless population, occupational therapy, supported housing, LaGrave on First, the chosen theoretical approach, suggested assessments, summary of literature review and our developed product. This scholarly project resulted in an evidence-based program plan that occupational therapists can utilize within a housing first facility.

Definition of Homelessness

Many definitions for homelessness exist. Health centers funded by the U.S. Department of Health and Human Services (HHS) use the following definitions:

- A homeless individual is defined in section 330(h)(5)(A) as “an individual who lacks housing (without regard to whether the individual is a member

> of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)]

An individual may be considered homeless if that person has no adequate housing, or becomes forced to live with family members or friends; or by staying at a residence that is not theirs through no choice of their own (National Health Care for the Homeless Council [NHCHC], 2011). Individuals may also may fall within the definition of homeless, if they did not have housing prior to going to a hospital or prison (NHCHC, 2011). It is important to identify an individual's circumstance and lifestyle to determine where they fall with the definition of homelessness (NHCHC, 2011). Programs funded by the U.S. Department of Housing and Urban Development
(HUD, 2017) use a more specific expanded definition of homelessness (p. 6-7):

- An individual who lacks a fixed, regular, and adequate nighttime residence
- An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car,

park, abandoned building, bus or train station, airport, or camping ground;

- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
- An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
- An individual or family who will imminently lose their housing [as evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days, having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause];

- An individual who has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing; and unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who have experienced a long-term period without living independently in permanent housing, have experienced persistent instability as measured by frequent moves over such period, and can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment (HUD, 2017) (p.6-7).

Demographic Characteristics

Individuals who are homeless constitute for approximately 1 in every 1,670 people in the United States (0.06% nationwide prevalence), and 100 million people worldwide (Homeless World Cup Foundation, 2018). On any given night, it is estimated that approximately 553,742 individuals will experience homelessness (HUD, 2017). The prevalence of homelessness in the world shows that it is not just a problem in the United States, but one that is prevalent worldwide.

Among the homeless population, 65% were involved with some form of shelter (emergency housing, hospitals, missions, etc.), while 35% did not have

any shelter (HUD, 2017). Homelessness prevalence has increased from 2016 to 2017, which is the first year that homelessness has increased in the last seven years (HUD, 2017). In addition, 12% of all homeless individuals are chronically homeless, meaning that they have been homeless for more than a one year period (HUD, 2017). Considering the homeless population, 26.2% have or meet criteria for diagnosed severe mental illness, and 34.7% have some form of substance use disorder (National Alliance to End Homelessness, 2012).

Seventy-one percent of all homeless individuals are male; with 45% of that population being over the age of 55 (HUD, 2017). White-Caucasian individuals make up the largest segment of the homeless population (52.2%), with African American (35.9%) and Native American (3.9%) to follow (HUD, 2017). California (112,756), New York (89,503) and Florida (32,190) have the highest rates of homelessness within the United States, and consequently, these states also have the highest rates of unsheltered individuals who are homeless (HUD, 2017). North Dakota (58%), Oregon (51.9%) and Wyoming (49.4%) are the states in which have the highest rate of unsheltered families who are homeless (HUD, 2017).

When considering groups of people who experience homelessness, 67% of all homeless are individuals, while 33% are families (HUD, 2017). Homeless individuals, with shelter, make up 35% of the population, unsheltered individuals are 32%. Thirty percent of families experiencing homelessness are sheltered, while 3% of homeless families are unsheltered (HUD, 2017). Of families experiencing homelessness, 40% are single female households with at least two

children (HUD, 2017). The rate of families experiencing homelessness has dropped by 2% from 2016 to 2017 (HUD, 2017).

One fourth of the entire population of individuals who are homeless report some form of disability or impairment keeping them from obtaining proper employment and/or housing (Pickett-Schenk, Cook, Grey, Banghart, Rosenheck, Rosenbeck & Randolph, 2002; HUD, 2017). Homelessness is associated with higher rates of constant stress. Constant stress can contribute to a decrease in physical health and well-being, especially when considering the duration of homelessness (National Coalition of the Homeless, 2014). Overall, it is evident that homelessness impacts many people, regardless of gender, age, occupation or ability.

Contributing Factors for Homelessness

When a person experiences homelessness, many factors have been found to contribute to the outcome. People, who are homeless, have been found to have similar variables including: existing mental illness, poor coping skills, poor financial management skills, substance use disorders, poor life decisions resulting in the loss of money or privileges, economic hardships, domestic abuse, and/or loss of employment to highlight the leading contributors (Raphael-Greenfield, 2011; Thomas, Gray, McGinty & Elringer, 2011; VanLeit, Starrett & Crowe, 2006). These comorbidities can lead to occupational deprivation and a decreased quality of life (VanLeit, Starrett & Crowe, 2006). Occupation is defined as: daily activities that an individual engages in that have meaning and value; occupations provide a sense of identity to an individual (American Occupational Therapy

Association [AOTA], 2014). Occupational deprivation will be expanded in the following paragraph.

Occupational Deprivation

Occupational deprivation is the notion that people have limited engagement in meaningful occupations, from factors that are often outside of their control (Thomas, Gray & McGinty, 2017; VanLeit, Starrett & Crowe, 2006). An individual who is homeless is limited from participating in many meaningful occupations due to confounding variables. A study by Herzberg and Finlayson (2001), found that participants risk of occupational deprivation increased when the occupations of work, stress management, community living skills and interpersonal/social skills were impacted. A person, who is homeless, is limited by: 1. insufficient access to financial means to participate in meaningful occupations, 2. preoccupation with current stressors related to reliable housing or 3. comorbid diagnoses of the population (Thomas, Gray & McGinty, 2017; VanLeit, Starrett & Crowe, 2006).

Decreased Community Assistance

According to Grandisson, Mitchell-Carvalho, Tang and Korner-Bitensky (2009), individuals who are seeking services to assist with cares, housing or assistance often require a residential address when signing up. Individuals who are homeless are unable to provide this information and are forced to provide false information or do not qualify for services. This prevents many individuals from receiving services to escape homelessness when services are available (Grandisson et al, 2009; VanLeit, Starrett & Crowe, 2006).

Substance Use

There is a large prevalence of substance use within the homeless community. The substance most likely to be used by a person experiencing homelessness is alcohol. Alcohol consumption as a coping strategy was reported by as many as 90% of the participants in a study performed by Fichter & Quadflieg (2006). Recent literature does not suggest a change in this large prevalence; 75% of hospitalizations for those who were homeless, in 2017, involved substance use (NHCHC, 2017).

Considering the comorbid presence of mental illness and substance use, individuals are challenged to find and participate in treatment (McNamara & Straathof, 2018; NHCHC, 2017; SAMSHA, 2017). Many substance abuse treatment centers decline clients who have unstable mental health or mental health illnesses (Siddiqui, Astone-Twewell & Hernitche, 2009). The denial of services to these individuals leaves them little to no treatment options (SAMSHA, 2017; VanLeit, Starrett & Crowe, 2006).

Substance use and not having a stable home strengthens the need for health services (The Homeless Hub, 2017). Individuals who are homeless often receive assistance regarding their home environment, but lack services to improve their mental health and well-being; including substance use (The Homeless Hub. 2017; SAMSHA, 2017). Individuals who are homeless are often excluded, marginalized and forgotten about when considering substance use treatment (Homeless World Cup Foundation, 2018; SAMSHA, 2017; Siddiqui, Astone-Twerell & Hernitche, 2009).

The contributing factors for those who are homeless increases overall vulnerability in both society and contexts. Occupational deprivation, decreased community assistance and substance use impact this level of vulnerability. The vulnerability that these individuals deal with negatively impacts the overall quality of life and well-being.

Vulnerability

The homeless population is at an increased risk of domestic abuse, assault, sexual assault, robbery and hate crimes (National Coalition for the Homeless, 2014). Persons who are homeless are often the victims of criminal acts. Research completed by the National Coalition for the Homeless (2014), stated that criminal acts towards individuals who are homeless are often non-lethal, but can be at times. When considering all crimes committed towards people who are homeless, 72% were non-lethal and 90% of those crimes were committed towards a male victim (National Coalition for the Homeless, 2014). The largest age group of individuals who were victims of criminal acts were less than 50 years of age (37%), with other age groups as follows: 40-49 years of age (28%), 30-39 (16%) and 20-29 (19%) (National Coalition for the Homeless, 2014). Statistically, an individual who is most likely to be victimized is a non-white, 44 year old, male (National Coalition for the Homeless, 2014). Individuals who are homeless also report being robbed 49% of the time. Items commonly stolen included: money (75%), identification cards (28%), medications (21%) and clothing (21%) (National Coalition for the Homeless, 2014).

Within the United States, areas with warmer climates and larger populations are more likely to have a higher rate of criminal acts occur towards individuals who are homeless (National Coalition for the Homeless, 2014). California, Florida, Texas, Oregon and Ohio were found to be the states with the most criminal incidents towards individuals who are homeless. California and Florida each had more reported incidents of criminal acts towards those who are homeless than Texas, Oregon and Ohio combined. In addition, when individuals who were homeless sought treatment or assistance after being victims of a crime, 68% were not able to financially afford the medical or legal services (National Coalition of the Homeless, 2014; HCH Clinicians' Network, 2002).

Myths

Those who are homeless are often stereotyped as being criminals, lazy and drug-addicted members of society (NHCHC, 2011; Zacharias, 2017). This population is often marginalized and ignored due to inaccurate stereotypes, and uneducated biases of the public. A change in society's attitudes and awareness are crucial to begin defeating these stereotypes that negatively impact those who are homeless (Zacharias, 2017).

Criminal Acts by the Homeless

Many of the arrests of individuals without stable housing involve petty crimes and non-aggressive behavior (NHCHC, 2013; Spiegelman and Green, 1999). One study showed that 62% of all arrests of homeless individuals were for nonviolent crimes and petty misdemeanors (jumping turnstiles, tenting without a permit within city limits, trespassing, and public intoxication) (Roy, Crocker,

Nicholls, Latimer, Reyes Allon, 2014; Spielgman & Green, 1999). Aggravated and violent crimes committed by individuals who were homeless often included either alcohol/drug use or mental illness (80%) (Roy et al., 2014; Spielgman & Green, 1999).

Ninety-five percent of all homeless individuals sampled in a study reported committing a criminal act during their duration of homelessness (Roy et al., 2014). Homelessness correlates with a higher rate of arrests and recidivism. Sixty-six percent of individuals report being arrested at least once during their duration of homelessness (NHCHC, 2011; Spielgman & Green, 1999). Diagnosed mental illness has been found to increase the rate of incarceration in individuals who are homeless (Roy et al., 2014). Individuals who are homeless with diagnosed mental illness have a lifetime incarceration prevalence of 62.9-90.0% (Roy et al., 2014). An increase in incarceration is also related to an increase in judicial punishment (Roy et al., 2014; NHCHC, 2013).

The time served for homeless individuals was also found to be more extensive than members of other populations (NHCHC, 2013; Spielgman & Green, 1999). Individuals who were homeless were 16% more likely to receive longer incarceration periods than those who had housing. Individuals who were homeless were also more likely to receive jail time instead of a fine for petty offenses (NHCHC, 2013). Extensive criminal records placed upon those who do not have stable housing negatively affect one's ability to obtain employment throughout life (Cho, 2015).

Work

Individuals who are homeless must overcome a variety of challenges in order to establish and maintain employment over time (Hoven, Ford, Willmot, Hagan & Siegrist, 2016). The most common obstacles amongst these individuals include: not sustaining stable housing, mental health illness and perceived stigma. Employers are less likely to hire an individual who does not have stable housing because of the lack of a permanent address, lack of reliable transportation or negative associations regarding homelessness (Hoven et al., 2016).

Pickett-Schenk et al., (2002) completed an extensive research study to determine the work histories of individuals who had mental illness and those who were homeless. Among the individuals in the study, 60% reported having jobs within the last year and 32% reported having employment and income 30 days prior to the study. When considering the sample, 19% reported not having a job and/or income within the last two years and 7.9% reported never obtaining full-time employment (Pickett-Schenk et al., 2002).

Work is an essential component of life for many people within society (Braveman & Page, 2012). Individuals who are homeless often have personal needs, as human beings, that can be met through work (Hoven et al., 2016). By obtaining employment and working, those who are homeless feel like they belong and are valuable members of the community (Hoven et al., 2016; VanLeit, Starrett & Crowe, 2006). Individuals who are homeless also experience other occupational areas in which needs are not met (Thomas, Gray & McGinty, 2017; Herzberg & Finlayson, 2001).

Needs of The Homeless Population

The needs of the homeless population are complex. The homeless population has needs related to both physical and mental task performance; each tied to their own respective well-being. Common needs of these individuals include: 1. understanding the utilization of resources, 2. discovering affordable housing, 3. obtaining and maintaining employment, 4. learning proper social interaction strategies, 5. handling legal issues and financial management (Thomas, Gray & McGinty, 2017; Stoffel, 2011; VanLeit, Starrett & Crowe, 2006; Herzberg & Finlayson, 2001;). Additional comorbidities often present within this population and challenge one's ability to meet their unique needs such as: mental health illnesses, substance abuse and insensitive practitioners (Thomas, Gray & McGinty, 2017; Stoffel, 2011; Herzberg & Finlayson, 2001).

The homeless population needs categorized by VanLeit, Starrett & Crowe (2006), determined where target intervention should be applied to help benefit this population most. The homeless population expresses the biggest concerns to: 1: Financial security, 2: Employment opportunities, 3. Transportation resources and 4. Housing/shelter options (VanLeit, Starrett & Crowe, 2006). All of the needs, identified for the homeless population, revolve around physical needs and resource utilization (VanLeit, Starrett & Crowe, 2006).

Homelessness and Physical Well-being

Chronic stress in one factor that has a large impact on deteriorated physical health and well-being (Davis, 2011). Homelessness has been found to be associated with high rates of constant stress and anxiety. Constant stress and

anxiety leads to the physiologic response of the body releasing cortisol to help cope. While cortisol is the body's normal reaction to stress, long term cortisol release in the body can be detrimental. Long term cortisol presence in the body leads to decreased cardiovascular health, decreased respiratory health, increased bone fragility and breakdown and decreased immune health. All of these factors contribute to increased susceptibility to disease and illness, increased breakdown of body tissues and systems, as well as an overall decrease in quality of life (Davis, 2011).

In addition to chronic stress, physical health is decreased by physical dysfunctions affecting individuals who are homeless (The Homeless Hub, 2015). Individuals who are homeless experience increased hospitalizations from: musculoskeletal injuries, lacerations, bruises, burns, malnutrition, respiratory illness, skin and foot health, sexual and reproductive care and dental issues (The Homeless Hub, 2015). While physical well-being decreases with increased duration of homelessness, mental well-being declines, as well.

Homelessness and Mental Well-being

When an individual experiences homelessness, participation in many valued occupations can begin to decline. The homeless population has been found to have a high rate of mental illness and mental health disorders (Fichter & Quadflieg, 2006; Pickett-Schenk, Cook, Grey, Banghart, Rosenheck and Randolph, 2002). Persons who experience homelessness can have up to twice as many health issues as an individual who has stable housing (Herzberg, Ray, Miller, 2006).

Several studies explored the mental status of individuals who experience homelessness. Fichter & Quadflieg (2006) found that 80.9% of their sample, of individuals who were homeless, had at least one diagnosed mental health disorder. These disorders included: acute depressive episodes, mood disorders, schizophrenia, psychotic disorders and anxiety disorders (Fichter & Quadflieg, 2006). Pickett-Schenk et al. (2002) found that approximately 82% of the their sample, self-reported they had at least one diagnosed mental health disorder, and 60% had at least two or more diagnoses. The most prevalent mental illness diagnoses were: Major depressive disorder, post-traumatic stress disorder (PTSD), anxiety disorders, and personality disorders (Pickett-Schenk et al., 2002).

VanLeit, Starrett & Crowe (2006), found several psychosocial factors that the homeless population considered important to address that were often lacking in daily life: time for self, sobriety, spirituality, self-cares, safety and social interaction. A study performed by Raphael- Greenfield (2012) looked at occupational needs that were lacking and what was hindering the individuals who were homeless. The needs identified of this study were: sequencing, initiating, cooking, financial management and health management (Raphael-Greenfield, 2012).

Coping strategies have been found to be largely maladaptive within the homeless community (Thomas, Gray, McGinty, & Elringer, 2011; Raphael-Greenfield, 2011; Fichter & Quadflieg, 2006). When individuals who are homeless have impaired coping strategies, the result is an increased rate of mental illness and decreased executive functioning capability (Thomas, Gray, McGinty,

2017; Thomas, Gray, McGinty & Elringer, 2011). The problems from increased mental illness and decrease cognitive capacity leads to an overall decrease in quality of life (McNamara & Straathof, 2018; Stoffel, 2011).

With impairments to physical and mental well-being, there is a need to provide services to individual who are homeless (Thomas, Gray, McGinty 2017; Raphael- Greenfield, 2011). The needs of the homeless population are vast, but providing housing is an option that has been highlighted as a solution to help achieve the needs (Lloyd & Bassett, 2012; Stoffel, 2011; Fichter & Quadflieg, 2006). Through providing housing, individuals are then able to address other occupational areas of need (Lloyd & Bassett, 2012; Stoffel, 2011; Roy et al., 2007; Fichter & Quadflieg, 2006; Herzberg, Ray & Miller, 2006; VanLeit, Starrett & Crowe, 2006).

Best Practices for the Homeless Population

Current best practice trends, identified through available literature, highlight the importance of supported housing and similar programs (Lloyd & Bassett, 2012; Stoffel, 2011; Bradley, Hersch, Reistetter & Reed, 2011; Roy et al., 2007; Fichter & Quadflieg, 2006; Herzberg, Ray & Miller, 2006; VanLeit, Starrett & Crowe, 2006; Finlayson, Baker, Rodman & Herzberg, 2002). Supportive housing programs can assist in determining if a client is mentally and physically ready to receive housing and maintain housing; as well as provide therapy to those individuals (Stoffel, 2011; Roy et al., 2007; Fichter & Quadflieg, 2006; VanLeit, Starrett & Crowe, 2006).

Treatment for Substance Use

Stoffel & Moyers (2004) completed a systematic review looking at what evidence-based interventions were best practice for substance use. Treatment interventions that have been most effective are: motivational interviewing, cognitive behavior therapy, brief interventions, and self-help groups (Stoffel & Moyers, 2004). Each evidence-based intervention is described below.

Motivational interviewing is treatment based on guiding a patient to improve their own behavior through encouragement and cognitive change to improve self-driven empowerment (Stoffel & Moyers, 2004). Cognitive behavioral therapy (CBT) is treatment gauged at targeting maladaptive thoughts, reducing problematic thinking and changing thoughts to promote healthy behaviors. CBT has extensive research supporting the usefulness of this intervention strategy when working with multiple populations; including those who use substance. Brief intervention is a treatment strategy aimed at targeting medium-risk individuals through interaction with primary health care professionals. Brief intervention is a process utilized at local clinics that treat substance use; in a quick meeting and follow-up. The last evidence-based treatment modality for substance-use is self-help groups. Self-help groups are largely composed of members working for the benefits of other members. Common self-help groups are alcoholics anonymous (AA) and narcotics anonymous (NA). Clients are welcome to come and go as pleased, but with the contingency that they wish to remain abstinent from substance-use (Stoffel & Moyers, 2004).

Supported Housing

Supported housing programs were developed to place homeless individuals in temporary or permanent housing projects to help them gain basic necessities, before they address secondary deficits (Fichter & Quadflieg, 2006; VanLeit, Starrett, & Crowe, 2006; Pickett-Schenk et al., 2002). Supported housing operates on the basic principle to provide homeless individuals with shelter (Roy et al., 2007; Finlayson, Baker, Rodman & Herzberg, 2002). Once shelter is provided, therapy services and other interdisciplinary professions are available to assist rehabilitation (Roy et al., 2007; Fichter & Quadflieg, 2006).

Fichter & Quadflieg (2006) found that global cognitive functioning increased and problem behaviors decreased within participants who were homeless and substance users after placement into supported housing. Individuals who were homeless were also found to benefit more from services available to them when in a structured environment (Fichter & Quadflieg, 2006; VanLeit, Starrett & Crowe, 2006). This research highlights the benefits of supported housing when working with the homeless population. This can help guide treatment of this population, by understanding what unique needs must be met before treatment can truly be beneficial. One aspect of supported housing that has published literature on effectiveness is the Housing First approach (Thomas, Gray & McGinty, 2017; Fichter & Quadflieg, 2006)

Housing First

Housing First is a supported housing option that provides immediate housing to individuals (Stoffel, 2011; Thomas, Gray & McGinty, 2010). Individuals are placed immediately into housing to meet the basic need for shelter, with no contingency for other services or payment required (Stoffel, 2011). Services are offered to individuals, but individuals are not required to participate in these services (Stoffel, 2011; Thomas, Gray & McGinty, 2010).

The non-committal aspect of the Housing First model has been found to be beneficial when allowing the responsibility of rehabilitation to be on the individuals seeking treatment (Roy et al., 2017; Thomas, Gray & McGinty, 2010). Therapy services, that are provided to these individuals, are often guided toward basic life skills, financial skills, coping skills, and occupational engagement (Thomas, Gray & McGinty, 2010). Therapy services within Housing First facilities often address: 1. Prevocational skills, 2. Communication skills, 3. Financial management, 4. Self-cares and, 5. Coping skills (VanLeit, Starrett & Crowe, 2006; Fichter & Quadflieg, 2006; Thomas, Gray & McGinty, 2010).

LaGrave on First (LaGrave)

Grand Forks, ND welcomed its very own Housing First project, to support those who are homeless within the community in the summer of 2018. An apartment complex, grounded by the Housing First model, has the capacity for 42 individuals. LaGrave in Grand Forks is currently still a work in progress to ensure quality medical services and therapies are delivered to residents (R. Roed, personal communication, September 10th, 2018).

As of December 2018, all 42 apartments have been filled by new residents to LaGrave. Apartments are designated for one individual, but consideration is being made on a case-to-case basis for couples or families who are experiencing homelessness (R. Roed, personal communication, 9-10-18). The facility has a large testing room available for privacy, two large conference rooms and two kitchenettes. Professionals that are planned to be staffed at LaGrave include: one full-time case manager (currently a registered nurse), one part-time physician, two part-time occupational therapists, one financial advisor and other professionals from the Northeast Human Service Center (R. Roed, personal communication, 9-10-18).

LaGrave has inclusion and exclusion criteria for tenants to ensure the population is safe and has a therapeutic environment (R. Roed, personal communication, 9-10-18). Criteria required to live at LaGrave is as follows: 1. individuals have to be homeless for at least one year total in the last three years 2. residents can not be on the federal registry of sex offenders, 3. residents cannot have a criminal charge for manufacturing methamphetamines and, 4. Residents are not required to be clean of alcohol or narcotics, but the environment of LaGrave will not foster these behaviors within the facility. Individuals will not be allowed to have substances in the commons areas and will not be allowed to have visitors who are visibly intoxicated on the premise (R. Roed, personal communication, 9-10-18).

LaGrave is one of only of a handful of facilities following the Housing First model in North Dakota (R. Roed, personal communication, 9-10-18).

LaGrave has the objective to capitalize on the strengths of it's residents and give back to the community, utilize groups to develop cohesive relationships and process together (R. Roed, personal communication, 9-10-18). The review of literature was completed to develop a product that can be utilized by the occupational therapists working at LaGrave.

Occupational Therapy

Occupational therapists (OTs) are prepared and able to address the variety of needs of the homeless (Griner, 2006). OTs have extensive knowledge about psychosocial and physical needs regarding areas of occupation (AOTA, 2014). Areas of occupation include the following: 1. activities of daily living (ADL's), 2. instrumental activities of daily living (IADL's), 3. work, 4. education, 5. leisure, and 6. sleep (AOTA, 2014). OT's are equipped with the skills to assist individuals in client-centered care, implement therapeutic use of self and provide a therapeutic relationship that can benefit the client while receiving care (AOTA, 2014). The ability to view a client as a holistic individual; not limited to their disease, disability or disorder is a strength of the profession. These strengths extend from the occupational therapist's comprehensive education on evaluation, assessment and intervention.

Occupational Therapy Education

According to AOTA (2018), an individual wishing to pursue a career in occupational therapy must obtain an academic occupational therapy degree from an accredited college/university, pass the board certification exam and become licensed in the state of desired practice. Occupational therapy educational

curriculum across the United States is currently designed to be either: Bachelors (OTA/R), Masters (MOT/R) or Doctorate (OTD/R) program of study (AOTA, 2018). In order to be deemed as an accredited university, academic curriculum must be pre-approved by the Accreditation Council for Occupational Therapy Education, often referred to as ACOTE (AOTA, 2018). ACOTE frequently reviews and determines the proper standards that classroom education must achieve in order to properly deliver OT services in practice.

Occupational Therapy and Housing First

Within Occupational Therapy literature, there is no template published to guide therapy service implementation within a housing first facility. This area of need was identified and a product was developed to fill this need. The product of this scholarly project is an occupational therapy template that can be used by therapists to address and target the unique needs of the homeless population.

An occupational therapist, within a Housing First program, can assist in determining if a client who is homeless is mentally and physically ready to receive and maintain housing; as well as provide therapy to these individuals (Stoffel, 2011). Occupational therapist can provide treatment geared toward a number of areas. These areas include: 1. coping skills (McNamara & Straathof, 2018; Stoffel, 2011; Fichter & Quadflieg, 2006) 2. functional behavior that can produces an increase in quality of life (Stoffel, 2011; VanLeit, Starrett & Crowe, 2006; Herzberg, Ray & Miller, 2006) and, 3. increasing participation in all areas of occupation (McNamara & Straathof, 2018; Stoffel, 2011; VanLeit, Starrett & Crowe, 2006; Fichter & Quadflieg, 2006; Herzberg, Ray & Miller, 2006).

Occupational therapy has established models of practice to support and encourage evidence-based practice (Cole & Tufano, 2008). The use of a practice model allows the occupational therapist to deliver interventions in a consistent manner to best meet the needs of the client (Cole & Tufano, 2008). Using an occupational therapy theoretical model will show the importance that the profession can bring to a Housing First facility. The product of this scholarly project, used the Ecology of Human Performance (EHP) as it's theoretical foundation.

Theoretical Approach

EHP was developed to be an interdisciplinary model that can be collectively used by healthcare professionals to assist clients and communicate in similar language to increase interdisciplinary understanding and collaboration (Brown, 2014; Cole & Tufano, 2008). One way to assist with increased interdisciplinary communication is the use of the word "task" in relation to what someone does (Brown, 2014). The model creators determined that the use of "task" will assist in increasing interprofessional understanding, by bringing collaborative terminology to the healthcare approach (Cole & Tufano, 2008).

EHP incorporates context and environment as an underlying factor for human performance, as well as other basic assumptions for performance (Brown, 2014; Cole & Tufano, 2008). Context is defined as an environment or circumstance that establishes circumstances that can facilitate or inhibit occupational participation (Brown, 2014). EHP has these basic assumptions to guide practice:

1. Occupational therapy practice begins by identifying what occupations the person wants or needs to perform
2. The relationship between people, occupations and the environment are all dynamic and unique to each individual
3. Occupational performance is determined by the merging/interaction of the person, environment, and occupation factors
4. The environment is a major factor in the prediction of successful and satisfying occupational performance
5. Rather than only using intervention to change a person, occupational therapists can more efficiently and effectively change the environment or find a better person environment match.
6. Occupational therapy practice involves promoting self-determination and the inclusion of people with disabilities in all environments (Brown, 2014)

In addition to these basic assumptions, EHP has three components, with sub-categories, that are used to understand occupational performance. The three components of EHP are the person, context and task; which all summate to occupational performance (Brown, 2014; Cole & Tufano, 2008).

The first component of EHP is the person (Brown, 2014). The person is defined as an individual who performs a task, and the innate abilities that comprise that individual. Abilities are broken down into subcategories including: sensorimotor, cognitive and psychosocial (Brown, 2014; Cole & Tufano, 2008). Sensorimotor abilities are physical components in which an individual possess (gross/fine motor coordination, physical strength, endurance, etc.) (Cole &

Tufano, 2008). Cognitive abilities are the mental processes in which an individual utilizes to comprehend and make judgements. (ex. reasoning, problem-solving, executive functioning, etc.) (Cole & Tufano, 2008). Psychosocial abilities are affective and emotional characteristics in which a person utilizes during interpersonal and intrapersonal relationships. (ex. attitude, motivation, open-mindedness, etc.) (Brown, 2014).

Context is the second major component of EHP (Brown, 2014). Context is an environment in which tasks are completed. Context is divided into four subcategories: physical, social, cultural and temporal (Brown, 2014). Physical Context are natural, tangible objects and aspects around an individual (buildings, furniture, tools and devices) (Brown, 2014). The cultural context is comprised of the customs, beliefs, ethnicity, values and/or religious affiliations an individual possess and finds meaningful (Cole & Tufano, 2008). Social Contexts are interpersonal relationships among peers, social groups, and social institutions in which a person is included within during occupation. Social context influences behavior and perceived norms of groups (Brown, 2014). A person's temporal context is the duration of time it will take to complete tasks (considerations for chronological age and lifespan development stage fall into temporal context) (Cole & Tufano, 2008).

The third component of EHP is task. The task is an activity that is completed by an individual to accomplish a goal (Brown, 2014; Turpin & Iwama, 2011). Task is anything that is completed by the person. A task develops into an occupation when an individual attaches meaning to the task (Brown, 2014).

The components of person, context and task summate into occupational performance (Brown, 2014). Occupational performance is the actual "doing" of the task and how competent a person is during task completion (Cole & Tufano, 2008). When factors of the person, context or task become impaired or limited, a person cannot participation in occupations, and thus limiting their occupational performance (Brown, 2014).

Occupational performance is a consideration for the homeless population due to limiting factors within the components of the person, context and task (VanLeit, Starrett & Crowe, 2006).

When the individual components are limited, EHP allows for intervention to address them through five different modalities. The 5 modalities of EHP intervention are: 1. establish/restore, 2. create, 3. alter, 4. prevent, and 5. adapt/modify (Brown, 2014).

Through the use of the five modalities, intervention guided by EHP can target a specific area that is limiting occupational performance, and assist in restoring abilities (Brown, 2014; Cole & Tufano, 2008). EHP uses the modalities to promote function, but does not disregard disability. EHP aims to improve function and occupational performance, even with the presence of disability (Brown, 2014; Cole & Tufano, 2008).

EHP has a process to use therapeutically that guide's therapy. One aspect of the therapeutic process that falls short within EHP is the lack of assessments for determining client's needs (Brown, 2014).

Assessments

EHP does not have assessments that are model-based, but does allow for tools from other models to be incorporated (Cole & Tufano, 2008). EHP instead operates on the base that tools from other models can be incorporated for assessment (Brown, 2014). Within the homeless population, there are unique challenges to assessment (Raphael-Greenfield, 2011; Finlayson, Baker, Rodman & Herzberg, 2002). Considerations of mental health, quality of life, physical disabilities and substance abuse can make assessment difficult for individuals who are homeless (Grandisson et al., 2009; Herzberg, Ray & Miller, 2006; Pickett-Schenk et al., 2002;). Literature has been published to assist in choosing the appropriate assessments for this population.

The literature highlights assessments such as: The Executive Functioning performance test (EFPT) and the Canadian Occupational Performance Measure (COPM) (Raphael-Greenfield, 2011; Herzberg, Ray & Miller, 2006; Finlayson, Baker, Rodman & Herzberg, 2002). The literature provides information that would be suggestive of using assessments such as: the Occupational Performance History Interview- II (OPHI-II), and the Assessment of Communication and Interaction Skills (ACIS) (Fuller, 2011; Bonsaksen, Myraunet, Celo, GranÃ, Kjell & Ellingham, 2011; Pickett-Schenk et al., 2002).

Executive Functioning Performance Test (EFPT)

The EFPT is an occupational therapy assessment tool that has been trialed to assess the complexities of a homeless client, and try to determine if a client is fit to benefit from skilled services. The assessment tool aims to better understand

an individual's performance in everyday tasks, and assess whether or not impairments exist (Baum & Wolf, 2013). The EFPT assesses cooking, using a telephone, medication management and financial management (Lipskaya-Velikovsky, Zeilig, Weingarden, Rozental-Iluz & Rand, 2018; Baum & Wolf, 2013). The EFPT has been documented to show effectiveness in determining a client's executive functioning skills and ability to live independently (Lipskaya-Velikovsky et al., 2018; Baum & Wolf, 2013). The effectiveness of this assessment tool has been researched for the homeless population and determining readiness for housing placement. Research failed to show significance in determining readiness, but was able to demonstrate identification of needs instead (Raphael-Greenfield, 2011).

Raphael-Greenfield (2011) discovered that the EFPT was useful in determining the needs of a client and what areas that the client required the most assistance with. Raphael-Greenfield (2011) also found that homeless individuals lack skills related to financial management and cooking more so than any other category within the EFPT. Individuals who are homeless also have difficulty with initiation and sequencing of actions, as well as having impairments in judgement and safety. The results of the study guided the organization and inclusion of interventions for IADL's included in the product of this scholarly project.

Canadian Occupational Performance Measure (COPM)

One occupational performance assessment tool that has extensive research and literature supporting use with the homeless population is the Canadian Occupational Performance Measure (COPM) (Law et al., 1991). The COPM is an

assessment tool that measures perceived efficacy and satisfaction in occupational performance of individuals (Carswell et al., 2004). Clients are able to rate their performance, satisfaction and identify goals with the therapist, making the tool client-centered and therapeutic for developing rapport (Carswell et al., 2004).

Research, regarding the COPM, was done to determine effectiveness and reliability of the assessment tool and research demonstrated strong evidence towards the benefits of using the COPM (Carswell, 2004). Several studies have shown that the COPM is easily incorporated into intervention and assessment (Herzberg & Finlayson, 2001; Law et al., 1998), it also provides a means for re-evaluation (Bottos et al., 2001), demonstrates clinical improvement and goal attainment (Cooper and Stewart, 1997), while delivering comfortable client-centered therapy (Carswell, 2004; Herzberg & Finlayson, 2001).

VanLeit, Starrett & Crowe (2006) used the COPM to assess goal attainment and satisfaction with housing placement and occupational satisfaction among the homeless. The use of the COPM was found to be beneficial and effective in determining if a client improved or perceived improvement, as well as was easily incorporated into general assessment of clients (VanLeit, Starrett & Crowe, 2006). The research concluded that the implementation of the COPM in assessment and follow-up evaluation was effective in determining the occupational needs and goals (VanLeit, Starrett & Crowe, 2006)

Model of Human Occupation Assessments

The Model of Human Occupation (MOHO) is a model that possess many assessment tools that fit with the foundation of EHP. Assessment tools of MOHO

often look at similar factors and hold similar assumptions to EHP, which makes utilization of these tools cohesive between models (Brown, 2014). The following assessments are those from a MOHO theoretical perspective.

Occupational Performance History Interview-II (OPHI-II)

The OPHI-II is an assessment looking into past occupational performance of clients, with consideration given to environments (Kielhofner, Mallinson, Forsyth & Lai, 2001). This assessment utilizes a self-report subjective experience of past occupational participation (Kielhofner, Mallinson, Forsyth & Lai, 2001). The OPHI-II gathers a base understanding of the client, what occupations they value, and what occupations they may not be participating in. (Kielhofner, Mallinson, Forsyth & Lai, 2001).

The OPHI-II assessment has documented effectiveness when working within mental health (Bonsaksen et al., 2011; Ennals & Fossey, 2007). The OPHI-II has demonstrated the effectiveness of identifying occupational participation and occupational deprivation (Kielhofner, Mallinson, Forsyth & Lai, 2001).

The subjective and self-report nature of the OPHI-II has not been directly used with the homeless population. The strengths of the assessment are all in areas which the homeless population has shown to have deficits according to literature (VanLeit, Starrett & Crowe, 2006; Fichter & Quadflieg, 2006). Using this assessment with the homeless population can assist with identifying the factors of occupational engagement, occupational deprivation and motivation for therapy (Bonsaksen et al., 2011; Ennals & Fossey, 2007; Kielhofner, Mallinson, Forsyth & Lai, 2001).

Assessment of Communication and Interaction Skills (ACIS)

The ACIS is an assessment aimed at understanding the social interaction skills of clients (Bonsaksen et al., 2011; Forsyth, Lai & Kielhofner, 1999). Social interactions are an area of occupation defined within the occupational therapy practice framework, which is vital to competent participation in everyday life (AOTA, 2014). When social interaction is impaired, in any way, a person is less able to communicate needs, access resources, or participate in occupations (Watson, Crawley & Kane, 2016; Lexén & Bejerholm, 2016; Jones, 2013). The literature supports that the ACIS is an assessment that provides a means to better understand a person's social interaction skills and identify any impairment (Watson, Crawley & Kane, 2016; Jones, 2013; Forsyth, Lai & Kielhofner, 1999).

The ACIS uses a group based interaction for assessment (Forsyth, Lai & Kielhofner, 1999). A therapist assesses a person social interaction skills and perceived abilities to gather information (Bonsaksen et al., 2001; Forsyth, Lai & Kielhofner, 1999). These skills are broken down into small components of each to get a better understanding of specifics that a client may have impairment with (Forsyth, Lai & Kielhofner, 1999). For example; a client may be able to communicate verbally, but not make eye contact or be within close physical proximity to others; while another case may be that a person will not communicate effectively, but be in close proximity or in fact touching another person during interaction. The ACIS is comprehensive enough to look at physical, communicative, and collaborative processes (Forsyth, Lai & Kielhofner, 1999).

The ACIS has shown effectiveness in the populations of mental health (Bonsaksen, Myraunet, Celo, GranÃ, Kjell & Ellingham, 2011; Fuller, 2011) and schizophrenia specifically (Yu-Chin, Beckstead, Su-Chen Lo & Chiu-Yueh, 2016). The ACIS has no specific research assessing its use with individuals who are homeless. Evidence does show that the factors impairing individuals who are homeless, are the same factors assessed through the ACIS however (Lexén & Bejerholm, 2016; Fuller, 2011; Thomas, Gray & McGinty, 2010). Factors such as proper social interaction skills (Jones, 2013; Thomas, Gray & McGinty, 2010), interpersonal relationships (VanLeit, Starrett & Crowe, 2006; Pickett-Schenk, 2002) and effective communication (Jones, 2013; Fuller, 2011; Petrenchik, 2006) have all been documented impairments within individuals who are homeless. With those factors in mind, the ACIS is a tool that has the properties to assess and identify what issues may be impairing an individual specifically (Bonsaksen et al., 2011; Forsyth, Lai & Kielhofner, 1999).

Summary

The homeless population often gets marginalized and forgotten in society, but it is a population that has a great amount of needs (Bradley, Hersch, Reistetter & Reed, 2011; Grandisson et al., 2009; Griner, 2006; Herzberg, Ray, & Miller, 2006). They have a unique set of variables that often make escaping homelessness impossible (Petrenchik, 2006; VanLeit, Starrett & Crowe, 2006; Herzberg & Finlayson, 2001). Providing occupational therapy to this population can help develop skills for an individual to return to meaningful occupational engagement (Fichter & Quadflieg, 2006).

Housing First is a best practice solution for those who are homeless because maintaining stable housing allows for further improvement of oneself. Based on the results of this literature review a product was developed to be utilized at LaGrave to guide occupational therapy services. The product is an evidence-based template that occupational therapists can use to deliver to the residents of LaGrave. Evaluation, assessment and interventions are included in the product to address key areas of occupation needed by individuals, who experienced chronic homelessness. The template was intended to supplement current interventions used by Altru Health Systems and should be used simultaneously with other forms of intervention for favorable outcomes. Occupational therapy assessment and intervention are organized based on evidence, best-practice and client-centeredness for residents of LaGrave.

Product Table of Contents

This scholarly project consists of remaining chapters that illustrate the creation and summation of the product. The remaining chapters of this scholarly project include: Chapter III, Chapter IV, and Chapter V. Chapter III contains the activities and methodology used to create the product. Chapter IV presents the organization of the product and the product itself follows the narrative. Chapter V presents a summary of the entire scholarly project.

CHAPTER III

Methodology

This scholarly project began with the exploration of identifying a topic that both occupational therapy students were interested in. Collaborative brainstorming began with the identification of an interest in a topic regarding mental health and the homeless population. A University of North Dakota (UND) Scholarly Commons search provided the occupational therapy students with previous studies and projects that had been completed regarding these topics. The UND Scholarly Commons identified a handful of literature resources related to the homeless population. The lack of occupational therapy literature in treatment for individuals who are homeless was seen as an area of need and was pursued further.

The original idea, proposed by the authors, was a marketing guide that occupational therapists could use to show distinct value among working with the homeless population in community-based settings. Shortly after conception of this scholarly project the occupational therapy department at the University of North Dakota was informed of an opportunity. The opportunity was that Altru Health Systems was looking for literature and resources for the occupational therapy implementation within LaGrave on First. The occupational therapy students and academic advisor met with Rhonda Roed, OTR/L, an occupational therapy department manager, at Altru Health Systems to discuss the creation of an

occupational therapy template that can be utilized to increase well-being and health promotion of individuals at LaGrave. It was mutually agreed upon that the occupational therapy students would develop a product that the occupational therapists of Altru Health Systems could use to address the areas of occupation with the greatest need according to individuals who are chronically homeless.

Research Gathering

A review of literature was conducted by using multiple databases. Databases of the literature search included: CINAHL, PubMED, PsycINFO, and the American Journal of Occupational Therapy. While using these databases, key search terms including: homeless, homelessness, occupational therapy, intervention and needs. Throughout the review of literature the occupational therapy students obtained statistics related to homelessness, factors and comorbidities associated with homelessness, needs of individuals who are homeless, and occupational therapy's role in intervention with this population.

The product was developed based on findings within literature and theoretical support from an occupational therapy model. The units of the product relate to the following areas of occupation: ADLs, IADLs, leisure, work and sleep. Addressing these specific areas of occupation will address the needs of the population and will improve well-being and health promotion of the residents of LaGrave on First.

Model Guiding Development

The theoretical model chosen to support this scholarly project was the Ecology of Human Performance (EHP) model. Other models were considered for

this product; however, EHP was chosen due to its sensitivity regarding one's environment or context (Brown, 2011; Cole & Tufano, 2008). Clients at LaGrave will deal with significant contextual changes when entering the apartment complex and becoming permanent residents. EHP's consideration to context solidified that this theoretical model would be the best fit for the scholarly project.

EHP considers the contextual environment in which occupations occur and the influence this can have on occupational performance (Brown, 2011; Cole & Tufano, 2008). Residents who are new to LaGrave will automatically deal with contextual changes and this will specifically impact occupational performance in all meaningful occupations (Brown, 2014; Cole & Tufano, 2008). Change within a variety of contexts including: time, environment, physical, and cultural can occur when an individual is provided with stable housing (Cole & Tufano, 2008). EHP addresses these specific contextual components which lead to the conceptualization of a product (Brown, 2014).

CHAPTER IV

Product

The *Well-being and Health Promotion Template* was developed to assist the Occupational Therapy Department at Altru Health Systems. Altru has recently began implementing therapy services at LaGrave on First, a housing first apartment complex, and a need was identified for a template to guide services. To fill this need, an extensive review of literature was done and this Template was created.

This template is organized into four sections with instructions for application. It consists of the following areas: a review of literature, terminology, theoretical model, and the therapeutic process (evaluation of person and task, evaluation of context, intervention implementation).

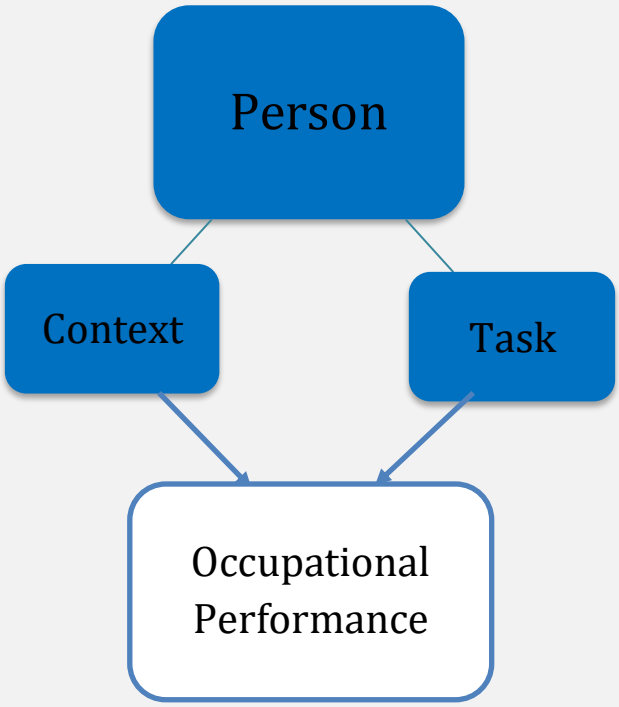
A review of literature is provided in the beginning of the product to establish an understanding of the population and the unique set of circumstances many individuals who are homeless experience. Areas of need and best practice interventions are highlighted. After the review of literature, a terminology page was designed and color coordinated throughout to present the common terms used in the product.

The model, guiding the product, is the Ecology of Human Performance (EHP). EHP contains assumptions aimed at understanding the importance of context and environmental factors that ultimately influence an individual's performance range (Brown, 2014). These components are crucial to consider when addressing the needs of the residents of LaGrave on First, due to difficulties sustaining a stable housing environment in the past. EHP identifies a therapeutic process that was utilized to organize the remainder of the Template.

EHP's therapeutic process is organized into three steps: 1. evaluation of person and task, 2.evaluation of context and, 3. intervention implementation. Steps one and two of the therapeutic process include assessment tools that aim to understand personal and contextual influences on occupational performance (Brown, 2014; Cole & Tufano, 2008). The third step, intervention implementation, takes assessment data gathered from the previous two steps and guides where intervention should be aimed to address deficits. Step three includes actual intervention groups that were created to for specific occupational areas of need. Interventions were organized within step three according to the areas of occupation depicted in the Occupational Therapy Practice Framework (OTPF) (AOTA, 2014). This template, in its entirety, is presented in the following pages.

Well-being and Health Promotion Template

Nichole Arn, MOTS
Cody Mach, MOTS
&
Dr. LaVonne Fox, Advisor



University of North Dakota
Department of Occupational Therapy
2018

Table of Contents

Introduction

The *Well-being and Health Promotion Template* was developed to assist Altru occupational therapy department when implementing occupational therapy services at LaGrave on First; a Housing First apartment complex in Grand Forks, North Dakota. The template was designed to supplement with interventions that address key areas of occupation needed by individuals who are experiencing chronic homelessness. The template was intended to supplement current forms of research and intervention used by the Altru occupational therapy department. The template provides evidence-based, holistic and client-centered care to residents of LaGrave on First.

The template utilizes a theoretical model to support the inclusion of evidence-based research throughout the therapeutic process. The model chosen to guide intervention, was the Ecology of Human Performance (EHP). EHP contains assumptions aimed at understanding the importance of context and environmental factors that ultimately influence an individual's performance range (Brown, 2014). These components are crucial to consider when addressing the needs of the residents of LaGrave on First, as they have had difficulties sustaining a stable housing environment in the past.

The template is presented in its entirety in the following sections and subsections with specific instructions for application and implementation at LaGrave on First. The template is organized in the following areas: purpose, review of literature, organization of the template, terminology, model of practice, and therapeutic process which includes: the assessment process, resulting evaluation outcome(s), and intervention implementation.

Purpose

Individuals, who are homeless, experience many chronic stressors that lead to deteriorated mental and physical health. These stressors often include: lack of security, safety, and resources (VanLeit, Starrett & Crowe, 2006). Housing First programs implement housing immediately for individuals who are homeless, to address one of these chronic stressors (Stoffel, 2011). By providing safe and stable housing to individuals, they can begin to remediate areas of their lives that were affected by chronic homelessness (Fichter & Quadflieg, 2006). These affected areas can include mental health conditions, substance use disorders and occupational deprivation (Fichter & Quadflieg, 2006; VanLeit, Starrett & Crowe, 2006).

This template was designed to be used by the occupational therapy department of Altru Health Systems at LaGrave on First. LaGrave on First is a Housing First apartment complex in Grand Forks, ND. The apartment complex was created to provide housing for individuals who are experiencing chronic homelessness within the community. LaGrave on First allows individuals with the opportunity to work on developing skills necessary to return to valued and meaningful occupations in order to stop the cycle of chronic homelessness.

As literature exists for Housing First programs, no template has been created that provides occupational therapy service implementation at a facility using this model of supported housing. This template fills a current need by providing an occupational therapy theory-supported, evidence-driven template that can be used with clients at LaGrave on First. The evaluation of person, task, context and intervention is specifically utilized to better serve individuals needs regarding well-being and health promotion.

Organization of Template

The template begins with a review of literature. The gathered literature highlights information relevant to working with individuals who are homeless, and the respective areas of need specific to occupational therapy service. Following the review of literature, a terminology list is provided and is followed by the theoretical model chosen to supplement the template.

The Ecology of Human Performance model (EHP) is the theoretical base for this template. EHP has assumptions relevant to occupational therapy, but also utilizes an approach that is supportive of interdisciplinary collaboration. EHP's therapeutic reasoning process is the means in which the template is organized. The steps used are not linear, and can be adapted for each individual client, based on presented client factors and performance range. The steps of EHP's therapeutic reasoning process are as follows: 1. Evaluation/assessment of person and task, 2. Evaluation/assessment of context, and 3. Intervention implementation (Brown, 2011).

The template is designed to be user-friendly and is an evidence-based tool to supplement the occupational therapy evaluation process, evaluation outcome(s), and interventions when treating individuals who experience chronic homelessness. Evaluation tools are described in Step 1 to ensure occupational therapists can determine the needs of the individuals that they are working with in therapy. After evaluations for person, task and context are presented, the intervention plan is listed to support the implementation of potential interventions to use with this population. Interventions are separated according to area of occupation, while also highlighting how they address and correlate with the EHP theoretical model.

The template is organized in a practical format. Each section has sub-sections that provide further guidance on how an occupational therapist can specifically apply the template to practice or more specifically, while working at LaGrave on First.

Review of Literature

Population

Individuals who are homeless constitute for approximately 1 in every 1,670 people in the United States (0.06% nationwide prevalence) and 100 million people worldwide (Homeless World Cup Foundation, 2018; SAMSHA, 2006). On any given night, it is estimated that approximately 553,742 individuals will experience homelessness (Department of Housing and Urban Development (HUD), 2017). The prevalence of homelessness in the world shows that it is not just a problem in our country, but one that is prevalent worldwide, and one that needs to be addressed immediately. Among the homeless population, 65% had some form of temporary shelter (emergency housing, hospitals, missions, etc.), while 35% did not have any shelter (HUD, 2017). North Dakota is among the states with the highest rates of unsheltered homeless families (58%) (HUD, 2017). The next two states with high rates of unsheltered homeless are, Oregon (51.9%) and Wyoming (49.4%) (HUD, 2017).

Homelessness prevalence has increased from 2016-2017, which is the first year that homelessness has increased within the last seven years (HUD, 2017). Of all homeless individuals, 12% reported that they are chronic homeless, meaning that they have been homeless for more than one year (HUD, 2017). Of the homeless population, 26.2% have or meet criteria for at least one diagnosed severe mental illness, and 34.7% have some form of substance use disorder (National Alliance to End Homelessness, 2012).

Contributing Factors for Homelessness

When a person experiences homelessness, many factors have been found to contribute to the outcome. People, who are homeless, have been found to have similar variables including: existing mental illness, poor coping skills, poor financial management skills, substance use disorders, poor life decisions resulting in the loss of money or privileges, economic hardships, domestic abuse, and/or loss of employment to highlight the leading contributors (Raphael-Greenfield, 2011; Thomas, Gray, McGinty & Elringer, 2011; VanLeit, Starrett & Crowe, 2006). These comorbidities can lead to occupational deprivation and a decreased quality of life (VanLeit, Starrett & Crowe,

2006). Occupation is defined as: daily activities that an individual engages in that have meaning and value; occupations provide a sense of identity to an individual (American Occupational Therapy Association [AOTA], 2014). Occupational deprivation will be expanded in the following paragraph.

Occupational Deprivation

Occupational deprivation is the notion that people have limited engagement in meaningful occupations, from factors that are often outside of their control (Thomas, Gray & McGinty, 2017; VanLeit, Starrett & Crowe, 2006). An individual who is homeless is limited from participating in many meaningful occupations due to confounding variables. A study by Herzberg and Finlayson (2001), found that participants risk of occupational deprivation increased when the occupations of work, stress management, community living skills and interpersonal/social skills were impacted. A person, who is homeless, is limited by: 1. insufficient access to financial means to participate in meaningful occupations, 2. preoccupation with current stressors related to reliable housing or 3. comorbid diagnoses of the population (Thomas, Gray & McGinty, 2017; VanLeit, Starrett & Crowe, 2006).

Decreased Community Assistance

According to Grandisson, Mitchell-Carvalho, Tang and Korner-Bitensky (2009), individuals who are seeking services to assist with cares, housing or assistance often require a residential address when signing up. Individuals who are homeless are unable to provide this information and are forced to provide false information or do not qualify for services. This prevents many individuals from receiving services to escape homelessness when services are available (Grandisson et al, 2009; VanLeit, Starrett & Crowe, 2006).

Substance Use

There is a large prevalence of substance use within the homeless community. The substance most likely to be used by a person experiencing homelessness is alcohol. Alcohol consumption, as a coping strategy, was reported by as many as 90% of the participants in a study performed by Fichter & Quadflieg (2006). Recent literature does not suggest a change in this large prevalence; 75% of hospitalizations for those who were homeless, in 2017, involved substance use (NHCHC, 2017).

Considering the comorbid presence of mental illness and substance use, individuals are challenged to find and participate in treatment (McNamara & Straathof, 2018; NHCHC, 2017; SAMSHA, 2017). Many substance abuse treatment centers decline clients who have unstable mental health or mental health illnesses (Siddiqui, Astone-Twewell & Hernitche, 2009). The denial of services to these individuals leaves them little to no treatment options (SAMSHA, 2017; VanLeit, Starrett & Crowe, 2006).

Substance use and the lack of stable housing strengthens the need for health services (The Homeless Hub, 2017). Individuals who are homeless often receive assistance regarding their home environment, if applicable, but lack access to services that could improve their mental health and well-being; including substance use (The Homeless Hub. 2017; SAMSHA, 2017). Individuals who are homeless are often excluded, marginalized and forgotten about when considering substance use treatment (Homeless World Cup Foundation, 2018; SAMSHA, 2017; Siddiqui, Astone-Twerell & Hernitche, 2009).

The contributing factors for those who are homeless increases overall vulnerability in both society and contexts. Occupational deprivation, decreased community assistance and substance use impact this level of vulnerability. The vulnerability that these individuals deal with negatively impacts the overall quality of life and well-being.

Mental Health

The homeless population has been found to have a high rate of mental illness and mental health disorders (Pickett-Schenk, Cook, Grey, Banghart, Rosenheck and Randolph, 2002; Fichter & Quadflieg, 2006). Persons who experience homelessness can have up to twice as many health issues as an individual who has stable housing (Herzberg, Ray, Miller, 2006). Several studies have been completed that assessed the mental health status of individuals who experience homelessness. A study performed by Fichter & Quadflieg (2008) found that of their sample, 80.9% of individuals had at least one diagnosed mental health disorder. These disorders ranged from acute depressive episodes, mood disorders, schizophrenia, psychotic disorders and anxiety disorders (Fichter & Quadflieg, 2008). Another study that included self-reported data, found that approximately 82% of the sample of individuals, who were homeless, had at least one diagnosed mental health disorder, and 60% with at least two or more diagnoses

(Pickett-Schenk et al., 2002). The study found the most prevalent mental illness diagnoses were: major depressive disorder, post-traumatic stress disorder (PTSD), anxiety disorders, and personality disorders (Pickett-Schenk et al., 2002).

Coping strategies have been found to be largely maladaptive within the homeless community (Fichter & Quadflieg, 2006; Thomas, Gray, McGinty, & Elringer, 2011, Raphael-Greenfield, 2011). Individuals, who are homeless, are presented with more stress and a lack of effective coping strategies. This combination can lead to overall health decline of an individual (Fichter & Quadflieg, 2006). The presence of poor coping skills, decreased health and increased stress contributes to the development of mental health disorders (Fichter & Quadflieg, 2006). Poor coping strategies, with increased anxiety and constant stress increases an individual's risk for schizophrenia and other mental illness, as well as overall decreased quality of life (Davis, 2011).

Physical Health

Chronic stress is one area of concern that has a large impact on deteriorated physical health and well-being (Davis, 2011). Constant stress and anxiety leads to the physiologic response of the body releasing cortisol to aid the body in coping (Davis, 2011). Long term cortisol presence in the body leads to decreased cardiovascular health, decreased respiratory health, increased bone fragility and breakdown and decreased immune system health (Davis, 2011). All of these factors contribute to increased susceptibility to disease and illness and an overall decrease in quality of life (Davis, 2011). Individuals who are homeless are exposed to countless chronic stressors that contribute to higher rates of chronic stress (VanLeit, Starrett & Crowe, 2006). The highest chronic stressors for an individual who is homeless include: locating housing/shelter and food, maintaining safety, caring for family or self and securing employment (VanLeit, Starrett & Crowe, 2006).

Housing First

Housing First is a supported housing option that provides immediate housing to individuals (Thomas, Gray & McGinty, 2010, Stoffel, 2011). Individuals are placed with housing in order to meet the basic physical need for shelter, with no contingency for other services or payment required (Stoffel, 2011). Individuals who are placed into stable housing are anticipated to immediately improve due to obtaining shelter and safety. These individuals can then begin to work to improve other areas within their own

lives and increase overall health (Stoffel, 2011). Addiction, behavioral and recreational services are often offered to individuals, however, individuals are not required to participate in these services to continue utilizing a Housing First facility (Stoffel, 2011; Thomas, Gray & McGinty, 2010).

A unique component of the Housing First model is the contingency that therapy services are offered, but not required (Thomas, Gray & McGinty, 2010; Stoffel, 2011). This aspect has been found to be beneficial by allowing the responsibility of rehabilitation to be on the individuals seeking treatment (Thomas, Gray & McGinty, 2010; Roy et al., 2017). Therapy services that are available to these individuals are often geared toward basic life skills, financial skills, coping skills, and occupational engagement (Thomas, Gray & McGinty, 2010). Research has shown that when individuals within supported housing seek out and participate in services, they significantly improve and increase skills related to overall quality of life (Thomas, Gray & McGinty, 2010).

LaGrave on First

LaGrave on First is an apartment complex that can house up to 42 individuals who have been dealing with chronic homelessness. Inclusion and exclusion criteria has been established to ensure the population is safe and has the opportunity to live within a therapeutic environment (R. Roed, personal communication, September 10th, 2018). Criteria to be able to live at LaGrave is as follows: 1. individuals have to be homeless for at least one year total within the prior three years, 2. residents cannot be on the federal registry of sex offenders, 3. residents cannot have a criminal charge for manufacturing methamphetamines and, 4. Residents are not required to be clean of alcohol or narcotics, but the environment of LaGrave will not foster these behaviors within the facility (R. Roed, personal communication, September 10th, 2018).

Individuals and/or guests may be substance users, but they will not be allowed to have substances on the premises and will be encouraged to abstain from use (R. Roed, personal communication, September 10th, 2018). LaGrave has the objectives to capitalize on the strengths of its members to give back to the community, utilize groups to develop cohesive relationships and process together, and to help other homeless individuals within the community (R. Roed, personal communication, September 10th, 2018).

Terminology

Legend: Blue terms: Main terms outlined throughout the template
Maroon terms: Sub-categories of main terms

Assessment: A specific tool or instrument that is used to gather data about a client. Can be informal or formal (Brown, 2014).

Context: An environment in which tasks are completed (Brown, 2014). For this Template, EHP holds basic assumptions that the context is composed of four subcategories including: physical, cultural, social and temporal (Cole & Tufano, 2008).

> Physical Context: Natural, tangible objects and aspects around an individual (buildings, furniture, tools and devices) (Brown, 2014).
>
> Cultural Context: Customs, beliefs, ethnicity, values and/or religious affiliations an individual possess and finds meaningful (Cole & Tufano, 2008).
>
> Social Context: Interpersonal relationships among peers, social groups, and social institutions. Social context influences behavior and perceived norms of groups (Brown, 2014).
>
> Temporal Context: Duration of time it will take to complete tasks. Considerations for chronological age and lifespan development stage fall within temporal context (Cole & Tufano, 2008).

Evaluation: The process of gathering and interpreting data to better understand influences upon a client's performance (Brown, 2014).

LaGrave on First: Housing First apartment complex in Grand Forks, ND. Will be referred to simply as "LaGrave" throughout the template.

Occupation: Any task or combination of tasks performed in daily life that hold meaning to a person (Brown, 2014).

Occupational Deprivation: The absence or decreased participation in meaningful occupations (Brown, 2014). Can occur when one is not participating in meaningful occupations by their own choices or limitations; or when contextual barriers exist, then limiting overall participation (Brown, 2014).

Occupational Performance/ Task Performance: The "doing" of the task (Brown, 2014). All factors of person, task and context coming together to influence actual participation in an occupation (Cole & Tufano, 2008). Performance while participating in an occupation and perception upon how well the occupation was performed (Brown, 2014).

Person: An individual who performs a task, and the innate abilities that comprise that individual. Abilities are broken down into subcategories including: sensorimotor, cognitive and psychosocial (Brown, 2014; Cole & Tufano, 2008

Sensorimotor: Physical abilities that an individual possesses (ex. gross/fine motor coordination, physical strength, endurance, etc.) (Cole & Tufano, 2008).

Cognitive: Mental processes in which an individual utilizes to comprehend and make judgements. (ex. reasoning, problem-solving, executive functioning, etc.) (Cole & Tufano, 2008).

Psychosocial: Affective and emotional characteristics in which a person utilizes during interpersonal and intrapersonal relationships. (ex. attitude, motivation, open-mindedness, etc.) (Brown, 2014).

Interpersonal relationship: Relationships and interactions with other people (Brown, 2014).

Intrapersonal relationship: The understanding of and relationship with oneself. (Brown, 2014).

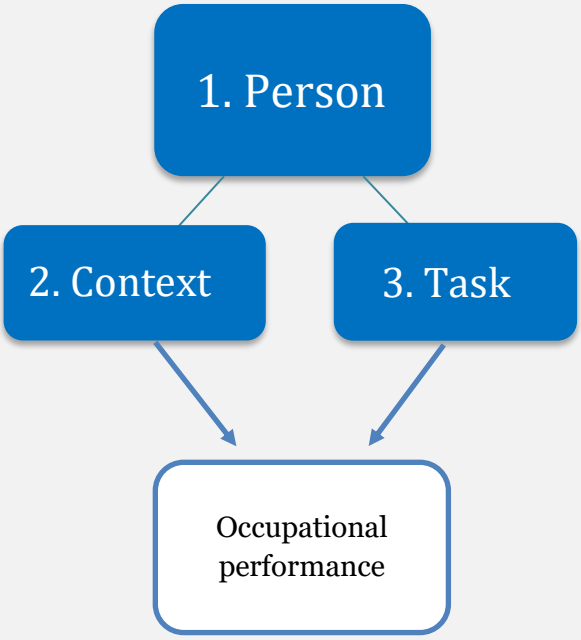
Task: An activity that is completed by an individual to accomplish a goal (Brown, 2014; Turpin & Iwama, 2011).

Model of Practice

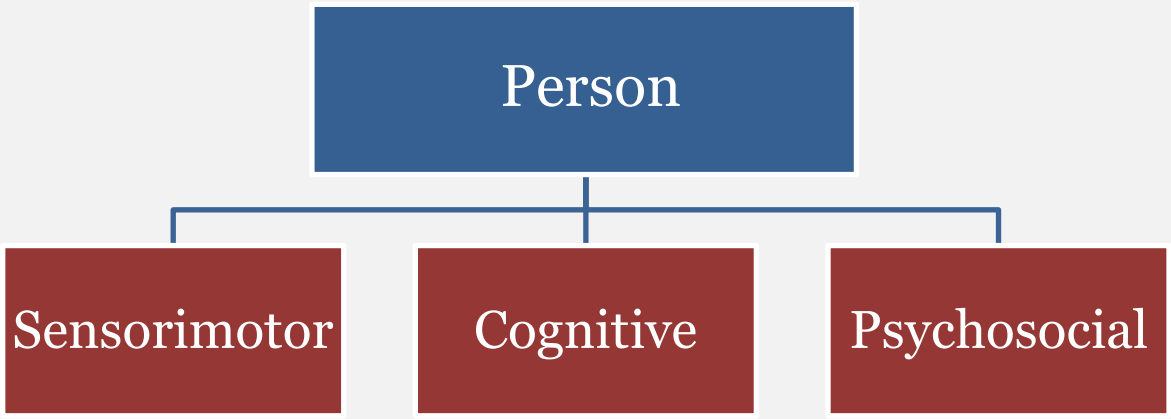
The Ecology of Human Performance model (EHP) is the guiding theoretical base for this template. EHP contains six basic assumptions that assist in the therapeutic process and with reasoning of an occupational therapist:

1. The interactions between the person and context are dynamic (Brown, 2014).
2. The context is a large factor in determining successful and satisfying occupational performance (Brown, 2014).
3. It is often more effective and efficient to change contextual factors, as opposed to person factors (Brown, 2014).
4. Occupational performance is a determinant of influence between the person, context and task (Brown, 2014).
5. Occupational therapy services should begin by assessing what occupations the person wants/needs to perform (Brown, 2014).
6. Occupational therapy services involve promoting self-determination and inclusion of all individuals with disabilities in multiple contexts (Brown, 2014).

In addition to these basic assumptions, EHP has three components, with sub-categories, that are used to understand occupational performance. The three components of EHP are the person, context and task (Brown, 2014).



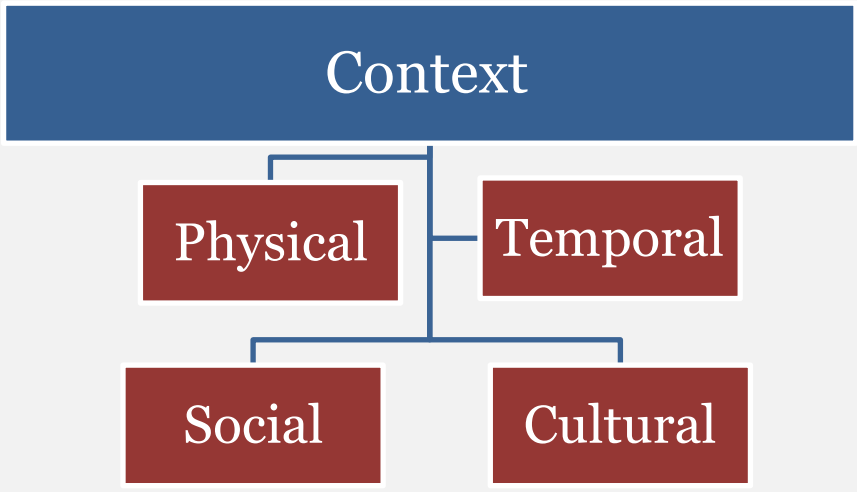
The Person is divided into: sensorimotor, cognitive and psychosocial factors.



Chronic homelessness impacts all three categories in different ways. Individuals can be affected by:

1. Physical disabilities and ailments (sensorimotor),
2. Impaired judgement, metacognition and insight (cognitive)
3. Impaired social interaction and emotional regulation (psychosocial) (Brown, 2014; Cole & Tufano, 2008, VanLeit, Starrett & Crowe, 2006).

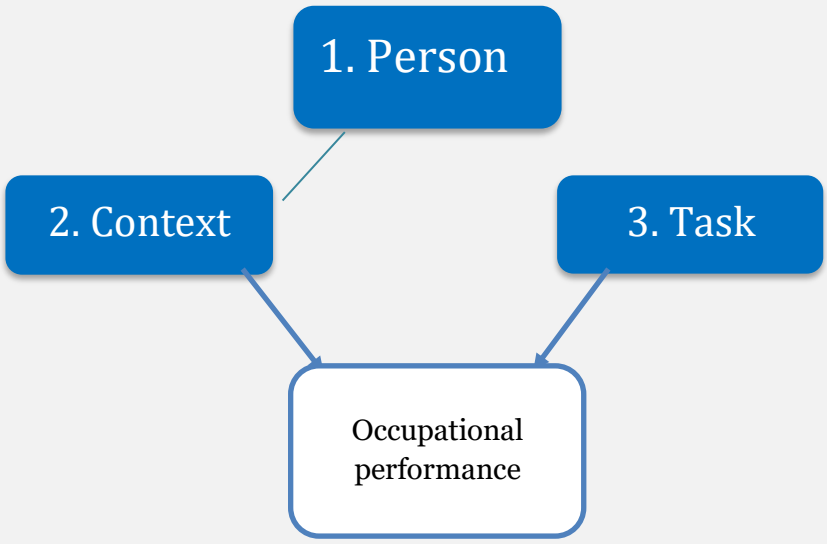
Context is the environment in which task performance occurs, and is divided into: physical, temporal, social and cultural (Brown, 2014).



All of the above factors and components summate into occupational performance (Brown, 2014).

Task

The third component of EHP is task. The task is an activity that is completed by an individual to accomplish a goal (Brown, 2014; Turpin & Iwama, 2011). A task develops into an occupation when an individual attaches meaning to the task (Brown, 2014).



- The components of person, context and task summate into occupational performance (Brown, 2014).
- Occupational performance is the actual "doing" of the task and how competent a person is during task completion (Cole & Tufano, 2008).
- Occupational performance is the ultimate goal for EHP. Increasing the range of tasks that an individual is able to participate in competently; this results in increased occupational performance (Brown, 2014).
- Successful engagement in occupational performance is crucial because individuals who are homeless often experience occupational deprivation. The lack of competent occupational engagement and participation leads to decreased satisfaction, decreased quality of life, and an increase in disorganized actions and behavior (Fichter & Quadflieg, 2006; VanLeit, Starrett & Crowe, 2006).
- When factors of the person, context or task become impaired or limited, a person cannot participation in occupations, thus limiting their occupational performance (Brown, 2014).

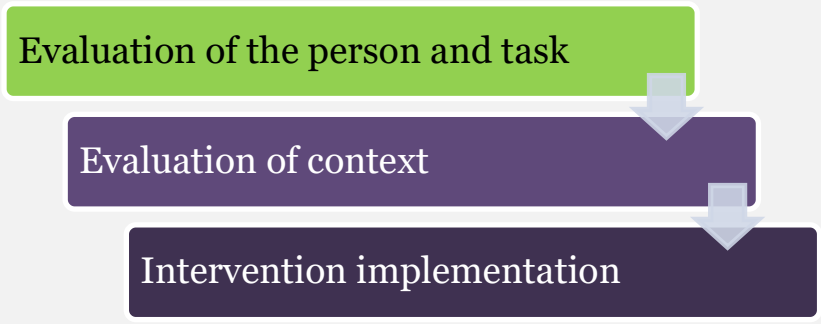
The Therapeutic Process

EHP guides the therapeutic process to aid in the delivery of occupational therapy services. This process was utilized to organize the template and to assist in making it user-friendly across the interdisciplinary team. The remaining portion of the template is organized according to the three steps of the therapeutic process:

Step 1: Evaluation of the person and task

Step 2: Evaluation of the context

Step 3: Intervention implementation

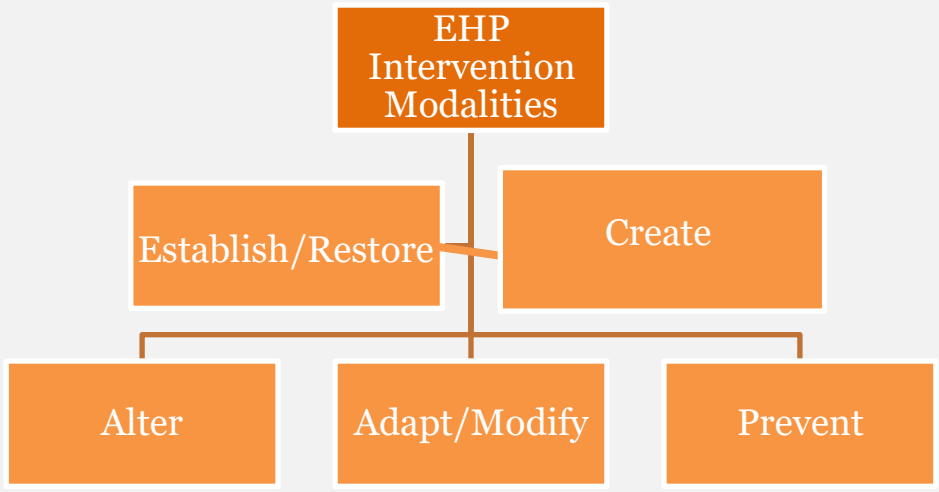


It is important to note that the organization of this template is not linear. The needs of the clients are unique and each individual may progress in different ways throughout therapy (Brown, 2014; Cole & Tufano, 2008). During the therapeutic process, if a client is: not progressing, becoming uninterested, or the needs do not match the intervention plan, previous steps should be revisited (Brown, 2014; Cole & Tufano, 2008).

EHP Intervention Modalities

Occupational performance is an area of concern for the homeless population due to limiting factors within the components of the person, context and task (VanLeit, Starrett & Crowe, 2006). When these components are limited, EHP allows for intervention to address the areas of concern through five different modalities. The five modalities of EHP intervention are: 1. establish/restore, 2. create, 3. alter, 4. adapt/modify, and 5. prevent (Brown, 2014).

Through the use of the five modalities, intervention guided by EHP can target a specific area that is limiting occupational performance and assist in restoring abilities (Brown, 2014; Cole & Tufano, 2008). EHP uses the modalities to promote function but does not disregard disability. EHP aims to improve function and occupational performance, even with the presence of disability (Brown, 2014; Cole & Tufano, 2008).



Establish/Restore: Developing/working to improve skills required to participate in meaningful occupations. Reestablishing prior roles and participation (Dunn, Brown & McGuigan, 1994)

> *Example:* Establish a health routine to promote participation and restore positive aspects of daily routines and habits

Create: Developing circumstances to facilitate higher complexity task performance (Dunn, Brown & McGuigan, 1994).

> *Example:* Providing an education session on how to cook a new meal. This enables the individual to begin to use the skill in daily life.

Alter: Changing the context surrounding a client performing a task, and selecting one that promotes the abilities of the client to perform tasks successfully (Dunn, Brown & McGuigan, 1994).

> Example: Changing a group session, to an individual session to better meet the level and needs of an individual who is homeless.

Adapt/Modify: Providing contextual benefits for a client. Changing factors of the context to increase competence and performance (Dunn, Brown & McGuigan, 1994).

> *Example*: Decreasing clutter around an apartment to facilitate increased effectiveness and timeliness of routine.

Prevent: Assuming no disability is present; developing contextual factors that deter the occurrence and development of poor performance (Dunn, Brown & McGuigan, 1994).

> *Example*: Providing financial management classes to an at-risk populations within the community to reduce likelihood of homelessness in the future.

How to Apply this Information at LaGrave:

An intervention is divided into these modalities to better meet the needs of the client. Depending upon the level of function of the client, different modifications might be required during intervention strategies. The occupational therapist can select a modality that best suits the needs of the client. Each intervention in this template lists modality approaches to use according to the client needs which are determined after evaluation. The modalities of EHP allow occupational therapists to encourage clients to engage in meaningful occupations while using an evidence-based, theory-supported approach.

Important Considerations

Needs of the Homeless Population

The needs of the homeless population are complex. The homeless population has needs related to both physical and mental task performance; each tied to their own respective well-being. Common needs of these individuals include: 1. understanding the utilization of resources, 2. discovering affordable housing, 3. obtaining and maintaining employment, 4. learning proper social interaction strategies and, 5. handling legal issues and financial management (Thomas, Gray & McGinty, 2017; Stoffel, 2011; VanLeit, Starrett & Crowe, 2006; Herzberg & Finlayson, 2001;). Additional comorbidities often present within this population and challenge one's ability to meet their unique needs such as: mental health illnesses, substance abuse and insensitive practitioners (Thomas, Gray & McGinty, 2017; Stoffel, 2011; Herzberg & Finlayson, 2001).

The homeless population needs categorized by VanLeit, Starrett & Crowe (2006), determined where target intervention should be applied to help benefit this population most. The homeless population expresses the biggest concerns to: 1: financial security, 2: employment opportunities, 3. transportation resources and 4. housing/shelter options (VanLeit, Starrett & Crowe, 2006). All of the needs identified for the homeless population revolve around physical needs and resource utilization (VanLeit, Starrett & Crowe, 2006).

Homelessness and Physical Well-being

Chronic stress is one factor that has a large impact on deteriorated physical health and well-being (Davis, 2011). Homelessness has been found to be associated with high rates of constant stress and anxiety. Constant stress and anxiety leads to the physiologic response of the body releasing cortisol to help cope. While cortisol is the body's normal reaction to stress, long term cortisol release in the body can be detrimental. Long term cortisol presence in the body leads to decreased cardiovascular health, decreased respiratory health, increased bone fragility and breakdown and decreased immune health. All of these factors contribute to increased susceptibility to disease and illness, increased breakdown of body tissues and systems, as well as an overall decrease in quality of life (Davis, 2011).

In addition to chronic stress, physical health is decreased by physical dysfunctions affecting individuals who are homeless (The Homeless Hub, 2015). Individuals who are homeless experience increased hospitalizations from: musculoskeletal injuries, lacerations, bruises, burns, malnutrition, respiratory illness, skin and foot health, sexual and reproductive care and dental issues (The Homeless Hub, 2015). While physical well-being decreases with increased duration of homelessness, mental well-being declines, as well.

Homelessness and Mental Well-being

When an individual experiences homelessness, participation in many valued occupations can begin to decline. The homeless population has been found to have a high rate of mental illness and mental health disorders (Fichter & Quadflieg, 2006; Pickett-Schenk, Cook, Grey, Banghart, Rosenheck and Randolph, 2002). Persons who experience homelessness can have up to twice as many health issues as an individual who has stable housing (Herzberg, Ray, Miller, 2006).

Several studies explored the mental status of individuals who experience homelessness. Fichter & Quadflieg (2006) found that 80.9% of their sample, of individuals who were homeless, had at least one diagnosed mental health disorder. These disorders included: acute depressive episodes, mood disorders, schizophrenia, psychotic disorders and anxiety disorders (Fichter & Quadflieg, 2006). Pickett-Schenk et al. (2002) found that approximately 82% of their sample, self-reported they had at least one diagnosed mental health disorder, and 60% had at least two or more diagnoses. The most prevalent mental illness diagnoses were: Major depressive disorder, post-traumatic stress disorder (PTSD), anxiety disorders, and personality disorders (Pickett-Schenk et al., 2002).

VanLeit, Starrett & Crowe (2006), found several psychosocial factors that the homeless population considered important to address that were often lacking in daily life: time for self, sobriety, spirituality, self-cares, safety and social interaction. A study performed by Raphael-Greenfield (2012) looked at occupational needs that were lacking and what was hindering the individuals who were homeless. The needs identified of this study were: sequencing, initiating, cooking, financial management and health management (Raphael-Greenfield, 2012).

Coping strategies have been found to be largely maladaptive within the homeless community (Thomas, Gray, McGinty, & Elringer, 2011; Raphael-Greenfield, 2011; Fichter & Quadflieg, 2006). When individuals who are homeless have impaired coping strategies, the result is an increased rate of mental illness and decreased executive functioning capability (Thomas, Gray, McGinty, 2017; Thomas, Gray, McGinty & Elringer, 2011). The problems from increased mental illness and decrease cognitive capacity leads to an overall decrease in quality of life (McNamara & Straathof, 2018; Stoffel, 2011).

With impairments to physical and mental well-being, there is a need to provide services to individual who are homeless (Thomas, Gray, McGinty 2017; Raphael-Greenfield, 2011). The needs of the homeless population are vast, but providing housing is an option that has been highlighted as a solution to help achieve the needs (Lloyd & Bassett, 2012; Stoffel, 2011; Fichter & Quadflieg, 2006). Through providing housing, individuals are then able to address other occupational areas of need (Lloyd & Bassett, 2012; Stoffel, 2011; Roy et al., 2007; Fichter & Quadflieg, 2006; Herzberg, Ray & Miller, 2006; VanLeit, Starrett & Crowe, 2006).

Providing housing to previously homeless individuals allows for improvement of occupational engagement. The following sections aim to evaluate the performance capabilities of the individuals when they arrive to LaGrave, or when beginning to participate in therapy services. Through evaluation, the therapist can begin to understand what occupational areas the client is deprived of.

Step 1: Evaluation of Person and Task

Evaluation of the Person and Task

Step 1

Occupational therapy services begins with the evaluation of the person and task (Brown, 2014). When an individual begins the therapeutic process supported by the EHP theoretical model; the individual's needs and wants are identified collaboratively between the individual and occupational therapist (Brown, 2014).

Evaluation is aimed at understanding where the client is when starting treatment. Personal factors, task performance and where the client wishes to be in goal attainment are specifically explored in this step (Brown, 2014). Evaluation is aimed at understanding the sensorimotor, cognitive and psychosocial components of the person, and the influence that they have on overall task performance, as well (Brown, 2014). To assist in the completion of evaluation, assessments used in this step are aimed at determining past performance in tasks and occupations, as well as identifying the holistic components of the person (Brown, 2014).

How to Apply Step 1 at LaGrave:

The following are assessments have been identified to provide the OT with an understanding of the client, and client's needs and wants:

A. To better understand a client, or potential client, the Canadian Occupational Performance Measure (COPM) can be utilized (Herzberg & Finlayson, 2001).
    - The COPM can provide subjective and objective information about a client (Carswell et al., 2004). The COPM provides subjective input into wants, needs, goals, and perceived occupational performance; while objectively measuring satisfaction through pre and post testing (Carswell et al., 2004).
    - Objective input is gathered by asking the client to rank their occupational performance on a numeric scale (Carswell et al., 2004).
    - As therapy services are not required at LaGrave, administration of the COPM can be done at admission and be used as a reference for an individual once they become ready for therapy services.
    - The COPM can be a therapeutic tool to develop a therapeutic relationship between the client and therapist and allows for mutual understanding for the client's specific therapeutic process, when appropriate (Carswell et al., 2004).

B. At the time that an individual feels ready for therapy services, other assessments can be completed to determine the best approach during therapy service delivery and by establishing a baseline in performance.
    - Assessments including the Executive Function Performance Test (EFPT) and the Occupational Performance History Interview-II (OPHI-II) are all aimed at understanding task performance, with some consideration to context (Baum et al., 2008; Kielhofner, Mallinson, Forsyth & Lai, 2001). Through administration of these further assessments, the client's wants and needs can be better understood. Areas of need within the homeless population include Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) performance, which is assessed through the mentioned instruments (VanLeit, Starrett & Crowe, 2006; Thomas, Gray & McGinty, 2011).
    - The OPHI-II also incorporates assessment into contextual factors, which is included in Step 2 of this Template. The OPHI-II can be used for both Steps 1 and 2, but appropriateness should be assessed for use with each client (Kielhofner, Mallinson, Forsyth & Lai, 2001).

These assessments were chosen to be included in the template due to their usefulness in assessing the areas of need that were identified in the literature. The COPM identifies self-perceptions among participation in all areas of occupation, which are often disrupted through homelessness. The EFPT and OPHI-II look to assess areas of ADLs and IADLs that could be affected and deprived due to homelessness.

The table below is a brief summary of each assessment tool described above. The table is comprised of the assessment tool, how to access it and if there is a financial cost, the components of the tool for administration and the information obtained by using it. The information below is not all encompassing; but additional information can be found in an internet search.

Table 1: Summary of Person and Task Assessment Tools

Assessment	Components of tool	Information obtained
Canadian Occupational Performance Measure (COPM) **Cost:** $50 for three packages of 100 evaluation forms **Location:** http://www.thecopm.ca/	-Subjective input by client -Perceived participation and importance of occupations -Categorization and ranking of occupations (translating to needs and wants) -Can be done by client alone, or with assistance of staff -Goal establishment with client -Client-centered tool (Carswell et al., 2004)	-Base for understanding client's needs and wants -Tool to re-assess occupational participation -Collaborative goal writing (Carswell et al., 2004)
Executive Functioning Performance Tool (EFPT) **Cost:** Free - only stipulation is that you notify Caroline Baum via email (baumc@wustl.edu) about download and use **Location:** https://www.ot.wustl.edu/about/resources/executive-function-performance-test-efpt-308	-Observation of client performing activities -Activities consist of IADLs: medication management, using a telephone book to complete a telephone call; etc. -Completed by the client with as little help from staff as possible -Goal establishment with client -Client centered tool (Baum, Connor, Morrison, Hahn, Dromerick & Edwards, 2008)	-Client's ability to complete tasks independently -Tool to objectively assess performance (Baum et al., 2008)
Occupational Performance History Interview- II (OPHI-II) **Cost**: $40.00 - one-time fee for facility. **Location**: MOHO Clearinghouse website https://www.moho.uic.edu/products.aspx	-Semi-structured interview, self-report and narrative -4 point rating scale based on professional judgement -Goals are created by both the client and therapist in a collaborative manner (Kielhofner, Mallinson, Forsyth & Lai, 2001)	-Tool to assess client's occupational life history, occupational competence, occupational identity and the environments throughout the life -Client specific information gathered from occupational role, daily routines, environment activities/occupational choices and critical life events (Kielhofner, Mallinson, Forsyth & Lai, 2001)

Step 2: Evaluation of Context

Evaluation of Context

Step 2

This is the evaluation of the contexts that the client currently engages in. Step 2 builds upon the foundational assessments mentioned in Step 1 and aims to understand contextual circumstances influencing the person and task (Brown, 2014). Through this step, assessment gains a better understanding of how the person interacts with contexts and how occupational performance can be impacted (Brown, 2014). Contextual assessment is recommended since LaGrave is a new context for the residents. The assessment can determine what contextual barriers a client may be experiencing that is limiting participation within LaGrave.

A. Ideally, the Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS) is recommended for a broader understanding of the client and contexts of the past that affect occupational performance (Haglund & Forsyth, 2013). The OCAIRS is often used to establish a baseline and as a reassessment tool once a person has transitioned to LaGrave (Haglund & Forsyth, 2013).
B. The Assessment of Communication and Interaction Skills (ACIS) assessment can be utilized during group based therapy services, to better understand the client. Social interaction skills can be negatively affected by chronic homelessness (Forsyth, Lai, & Kielhofner, 1999) and the impact can be hard to determine through an assessment. When and if appropriate, a client who is willing to participate in group-based services, can be assessed using this tool. The ACIS can be utilized to gather information about the ways that an individual communicates with those around them (Forsyth, Lai, & Kielhofner, 1999).
C. The OPHI-II, if not completed during Step 1, can serve as a useful tool for assessment of context. Occupational performance of the past and context information can be obtained and be utilized to assess what interventions would be best suited for the client. All assessments in Step 2 can be utilized to understand contextual information and can be applied for the preparation of Step 3.
D. Important note: The Residential Environment Impact Scale (REIS) assessment is a tool to be used to assess LaGrave itself. The tool can be utilized by therapists after therapy service implementation has begun to evaluate the effectiveness of the services provided. The REIS assessment can serve as a tool to determine if therapy services are effective and beneficial at LaGrave.

The assessments were chosen to be included in this template due to their usefulness in assessing the areas of need that were identified in the literature. The OCAIRS & OPHI-II can be used to identify the contextual factors that are limiting participation in occupations of the individuals. The ACIS is utilized in this template to assess an individual's social interaction skills and abilities to communicate within their social context.

The table below is a summary of each assessment tool mentioned above. The table is comprised of what the assessment tool is, how to access it and if there is a financial cost, the components of the tool for administration and the information obtained by using it.

Table 2: Summary of Contextual Assessments

Assessment	Components of tool	Information obtained
The Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS) **Cost**: $40.00- one-time fee for facility **Location**: MOHO Clearinghouse website: https://www.moho.uic.edu/products.aspx	-Semi-structured interview layout -Self-reported information -Subjective viewpoint about life and circumstances -FAIR 4-point rating scale for inventory (Haglund & Forsyth, 2013)	-Understanding about roles, routines, past experiences, and social and physical contexts -Importance of occupational participation in role of mental health and well-being -Can be reapplied after transition to LaGrave to determine effectiveness of context change. (Haglund & Forsyth, 2013)
The Assessment of Communication and Interaction Skills (ACIS) **Cost:** $40.00 - one time fee for facility **Location:** MOHO Clearinghouse website: https://www.moho.uic.edu/products.aspx	-Standardized observation and criterion-referenced assessment -4-point rating scale to identify the client's abilities with 22 communication skills (Forsyth, Lai, & Kielhofner, 1999).	-To gather data related to the client's skills when communicating and interacting with others -Identifies whether a communication skill is present or not; unable to identify underlying causes for lack of skill (Forsyth, Lai, & Kielhofner, 1999).

The Occupational Performance History Interview - II (OPHI-II) **Cost:** $40.00 - one-time fee for facility **Location:** MOHO Clearinghouse website: https://www.moho.uic.edu/products.aspx	-Semi-structured interview, self-report and narrative -4-point rating scale based on professional judgement -Goals are created by both the client and therapist in a collaborative manner (Kielhofner, Mallinson, Forsyth & Lai, 2001)	-Tool to assess client's occupational life history, occupational competence, occupational identity and the environments throughout the life -Client specific information gathered from occupational role, daily routines, environment activities/occupational choices and critical life events (Kielhofner, Mallinson, Forsyth & Lai, 2001)
Residential Environment Impact Scale (REIS) **Cost:** $40.00 **Location**: MOHO Clearinghouse website: https://www.moho.uic.edu/products.aspx	**-*This assessment is for LaGrave itself and for client satisfaction/benefit** -Looking at how well services are implemented and beneficial for clients -Staff and client's perspectives considered -Organization of the facility and services -Retrieves actual consumer information, and can be reassessed -Subjective information -Consulting tool (Fisher & Kayhan, 2012)	**-**Information revolving around how well the facility is managed and where services can be better -Appraisal and reflection of services (ex. benefits of treatment) -Reassessment potential after therapy service implementation (Fisher & Kayhan, 2012)

Step 3: Intervention Implementation

Intervention implementation

Step 3

The final step while following the suggestions of EHP is utilizing the evaluation data from Steps 1 and 2 and organizing it into interventions. Based on the assessment results from the evaluation, a variety of needs and wants of an individual are developed, as well as, the various contexts revolving around task performance (Brown, 2014). Step 3 includes taking the needs and determining which are of the highest importance to address in therapy and which needs will be most meaningful to the client (Brown, 2014; Herzog & Finlayson, 2001). Step 3 should be planned according to which areas of occupation needs to be addressed and interventions should be graded to match the person and associated sensorimotor, cognitive and psychosocial skills (Cole & Tufano, 2008).

The template is organized in a manner representing the different areas of occupation addressed in the Occupational Therapy Practice Framework (OTPF) (AOTA, 2014). Each intervention has been separated according to the modalities of EHP that were addressed to assist the occupational therapist in understanding how the model is incorporated into each intervention. The interventions, chosen for the template, focused on the needs that were presented within the literature. Each area of occupation includes specific needs that those who are homeless often experience occupational deprivation in. The interventions were created accordingly to best address those needs in individual and group sessions.

Occupational Deprivation

Occupational deprivation is the notion that people have limited engagement in meaningful occupations, from factors that are often outside of their own control (Thomas, Gray & McGinty, 2017; VanLeit, Starrett & Crowe, 2006). An individual who is homeless is limited from participating in many meaningful occupations due to confounding variables. A study by Herzberg and Finlayson (2001), found that participants risk of occupational deprivation increased when the occupations of work, stress management, community living skills and interpersonal/social skills were

impacted. A person, who is homeless, is limited by: 1. insufficient access to financial means to participate in meaningful occupations, 2. preoccupation with current stressors related to reliable housing or 3. comorbid diagnoses of the population (Thomas, Gray & McGinty, 2017; VanLeit, Starrett & Crowe, 2006).

It is important to note, that even though this template sets out specific interventions to use as tools, it should not be used alone, but with other intervention methods, as well. This template can be used to assist during occupational therapy services and is open for alteration, interpretation, and adjustments as needed by the occupational therapy staff at LaGrave. Additional interventions can be used or existing interventions can be altered to better meet the need of the population at the facility.

Table 3 lists all of the interventions within the template. The interventions are divided into five units, each representing the areas of occupation from the OTPF, that were chosen to address when working with the population. Each unit of the template contains two or three intervention sessions. Units two and four have three interventions each; while units one, three and five have two intervention sessions; respectively. The units, that have three interventions, were identified in the literature as larger areas of need for the homeless population.

Interventions are organized beginning with purpose, leading into theoretical approach, and finishing with a general description of the task and follow-up questions to use with the client or the group. EHP modalities are listed within each intervention table and the modalities can be selected upon appropriateness with the needs of the client or the group. More than one modality can be utilized, if appropriate, as well.

Table 3: Interventions

Units	Session I	Session II	Session III
Unit I: Activities of Daily Living (ADL)	The Meaning of Home	Creating a Daily Routine	X
Unit II: Instrumental Activities of Daily Living	Managing Monthly Expenses	Healthy Food Cooking Group	Where am I Going?
Unit III: Leisure	Art Self-Expression	What Interests Me?	X
Unit IV: Work	What Skills do I Have?	Where do I Want to Be for Employment?	Where do I Want to Be for Volunteering?
Unit V: Sleep	Creating an Evening Sleep Routine	Progressive Muscle Relaxation	X

Unit I:

Activities of Daily Living:

Session I: The Meaning of Home
Session II: Creating a Daily Routine

The interventions included in this unit aim to address the need for self-care routines and responsibility of one's own property. These needs were identified in literature and fall within the ADL section of the OTPF. Each need is addressed respectively through the two intervention sessions within this unit. The interventions aim to develop and create the self-care skills needed to foster independence and healthy occupational engagement.

Session I: The Meaning of Home	
Purpose:	Individuals who are new to LaGrave can often feel a "disconnect" to the community and do not feel a sense of ownership of possessions or responsibility towards objects (VanLeit, Starrett & Crowe, 2006). By creating a log of personal items, the client will be able to identify what objects they currently possess and a sense of ownership and responsibility for these items (VanLeit, Starrett & Crowe, 2006). The activity will support communication through collaboration between the client and therapist and the sense of responsibility and pride when identifying one's personal belongings. This intervention addresses the need for the client to responsibly care for and take ownership of the items that they own.
Evidence Based Rationale & Source:	● Thomas, Y., Gray, M. A., McGinty, S. (2017). The occupational wellbeing of people experiencing homelessness. *Journal of Occupational Science, 24*(2), 181-192. doi: 10.1080/14427591.2017.1301828 ● VanLeit, B., Starrett, R., & Crowe, T. K. (2006). Occupational concerns of women who are homeless and have children: An occupational justice critique. Hawthorne Press, Inc. doi: 10.1300/j003v20n03_04
Objectives:	1. Clients will understand the importance of organization in daily living 2. Clients will attempt to identify the purpose and meaningfulness of their own personal belongings 3. Clients will establish a sense of ownership and responsibility for their own belongings
Amount of Time Needed:	45-60 minutes ● 10 minutes for introduction and set-up ● 20-30 minutes for task ● 15-25 minutes for discussion
Person:	Designed for the individual who has just moved in or is in the process of preparing to move into LaGrave. This intervention was developed as an individual session with the therapist and client. The activity focuses on identifying personal items, exploring the meaning of these items and initiating ownership of their belongings. The session is appropriate for clients who vary in cognitive ability. The therapist can grade the activity to meet the needs of the client, as explained below.

Context:	Preferably, the session will occur at LaGrave. Be sure to consider the individual's age, life cycle and if the environment is supportive for individuals.
Task/Activity: (check all that apply)	In this activity, the client will individually create a personal data sheet with all of the belongings that they bring with them to LaGrave.
Establish /Restore ✓	If the OT needed to establish/restore the skills required to participate in this task you could consider: 1. The client can establish or restore a sense of ownership and responsibility for personal possessions
Alter ✓	If the OT needed to alter the context to promote the clients ability to perform the task, you could consider: 1. Doing the session in the individuals apartment 2. Doing the session in a general room at LaGrave
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. The inventory log can be adapted to be simple or complex. Depending upon the abilities of the client when expressing meaning and identifying belongings. The therapist and client will complete an inventory list together while organizing their belongings 2. If an individual is illiterate, the log can be read aloud to the client to promote increased understanding and participation
Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider:
Introduction:	During an episode of chronic homelessness, an individual often feels a sense of disarray (VanLeit, Starrett & Crowe, 2006). An individual who is homeless feels that they are not in control of the circumstances around them, and they often feel that they do not have any sense of ownership (Fichter & Quadflieg, 2006). It is important to address this factor within the context of LaGrave, because the individual will now have a safe physical environment in which they can call home. With new structure in their lives, individuals can begin to take ownership of decisions and

	circumstances. Individuals can begin to take control of their lives (Fichter & Quadflieg, 2006). Explain what the tasks of the session are Verbally mention and write the objectives of the session so the client is aware of what is trying to be accomplished during the session Ask if there are any questions before starting the session
Sharing:	1. Why do you think we did this activity? 2. Was any part of the activity challenging? 3. Please explain one of your personal belongings that you logged onto your sheet. Why did you choose to explain this object?
Processing:	1. How did this activity make you feel?
Generalizing:	1. What did you learn from this activity? -Sense of ownership? Responsibility? Security?
Application:	1. Can this activity help fostering a sense of belonging somewhere, and a sense of security and community? 2. How can this task be used to take ownership of other aspects of your life? -Aim this at individuals taking ownership of decisions -Individuals discovering that they control decision making and have responsibilities for their own decisions

Personal data sheet example:

Item	What it means to me? (ex. simple and/or meaningful objects)	Where should I keep it?

Session II: Creating a Daily Routine

Purpose:	Individuals who are homeless often lack a sense of consistency in their lives, and have little sense of routines for hygiene and personal care (VanLeit, Starrett & Crowe, 2006). Individuals are often preoccupied with other needs such as: finding shelter, food and safety; and are not worrying about routines for self-cares (Fichter & Quadflieg, 2006) or don't have the resources to access them. This task addresses the need by allowing clients to develop a daily routine for themselves. The intervention focuses on establishing an ADL routine to be used in order to support each individual's personal hygiene maintenance while at the facility and in the future. While completing this session, residents will work with other peers to promote socialization and positive growth when engaging in interpersonal communication
Evidence Based Rationale & Source:	● Thomas, Y., Gray, M. A., McGinty, S. (2017). The occupational wellbeing of people experiencing homelessness. *Journal of Occupational Science, 24*(2), 181-192. doi: 10.1080/14427591.2017.1301828 ● VanLeit, B., Starrett, R., & Crowe, T. K. (2006). Occupational concerns of women who are homeless and have children: An occupational justice critique. Hawthorne Press, Inc. doi: 10.1300/j003v20n03_04 ● Fichter, M. M., & Quadflieg, N. (2006). Intervention effects of supplying homeless individuals with permanent housing: a prospective study. Acta Psychiatrica Scandinavica, 113(49), 36-40. doi: 10.111/j.1600-0447
Objectives:	1. Client will create a personal morning and/or evening hygiene routine 2. Client will collaborate & understand the importance of routines, especially regarding hygiene and overall health 3. Clients will collaborate and share ideas with other group members regarding their morning and/or evening ADL routines a. Create a sense of community within LaGrave
Amount of Time Needed:	45-60 minutes ● 5-10 minutes for introduction ● 20-30 minutes for task

	• 20 minutes for group discussion
Person:	Individuals new to LaGrave, as well as individuals who have resided at LaGrave will benefit from this activity.
Context:	This group session will be implemented within the environment of LaGrave, more specifically, a community room.
Task/Activity: (check all that apply)	• This task will focus on structure and routine within an individual's life, while considering the assumption that other needs are being fulfilled while at LaGrave • Individuals will create a visual schedule that they can use to provide a sense of daily structure when completing personal hygiene maintenance
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Establish processing and sequencing skills needed to plan a routine for self-cares If the client needed to restore the skills required to participate in this task you could consider: 1. Restore normality and structured routines in a client's life and schedule
Alter ✓	If the OT needed to alter the context to promote the client's ability to perform the task, you could consider: 1. The session can be completed in a client's room if the client is overwhelmed by social context 2. The session can be completed in a small group setting to facilitate social interaction
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. This task can be completed by reading any written direction aloud if the client is illiterate 2. This task can be completed collaboratively one-on-one with the client through strategic questioning if they have trouble developing a routine
Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider:

	1. Creating a routine schedule for residents of LaGrave to use in their daily lives can promote structure for healthy choices in the future in regards to ADLs.
Introduction:	Developing a routine checklist of meaningful tasks, on any given day, will help promote organization of one's schedule and life (VanLeit, Starrett & Crowe, 2006) Explain what the tasks of the session are Using visual aids (ex. whiteboard, paper, etc), state the objectives so the client is aware of what is trying to be accomplished during the session Ask if there are any questions prior to beginning the session An example of a morning routine that could be described: 1. Wake up 2. Go to the bathroom and use the toilet 3. Shave (optional) 4. Shower 5. Put on clothes 6. Make the bed 7. Brush teeth and brush hair 8. Eat breakfast
Sharing:	1. What are some challenges to following a daily routine? 2. What does your current morning routine consist of? -What benefits could occur if you followed a routine?
Processing:	1. What was the most challenging part of developing your routine? 2. Was developing this routine easier than you thought it would be?
Generalizing:	1. How do you think the development of this routine can be applied to other activities that you do every day? -Shopping lists, to-do list, any scheduling task
Application:	1. When will you apply the routine that you created? 2. Will you need help when remembering to complete your routine? If so, who can you ask to help you?

Unit II:

Instrumental Activities of Daily Living:

Session I: Managing Monthly Expenses
Session II: Healthy Food Cooking Group
Session III: Where Am I Going?

This unit was developed to address the needs related to financial management, utilizing transportation resources and cooking. These areas were highlighted in the literature and are organized within the IADL section of the OTPF. There are three intervention sessions within this unit that address each area of need. Social participation is also addressed implicitly in each intervention through group interaction.

Session I: Managing Monthly Expenses

Purpose:	Poor management of finances and poor decisions on spending of money is a negative correlation with homelessness (VanLeit, Starrett & Crowe, 2006; Raphael-Greenfield, 2011). This activity addresses financial management by having individuals track their own flow of money for a one-month period. The clients will specifically list where their money was spent throughout the month while learning how to manage their finances. When clients mention where money was spent, they can learn whether or not they have made healthy decisions about money spending from the therapist and other group members (Nelson, Smith, Shelton & Richards, 2015). This activity will challenge maladaptive financial management strategies currently understood by clients, and assist them in learning new health strategies through social interaction and collaboration (Nelson, Smith, Shelton & Richards, 2015; Raphael-Greenfield, 2011; VanLeit, Starrett & Crowe, 2006).
Evidence Based Rationale & Source:	● Nelson, R. J., Smith, T. E., Shelton, V. M., Richards, K. V. (2015). Three intervention for financial therapy: fostering an examination of financial behaviors and beliefs. Journal of Financial Therapy, 6(1), 33-45. ● Raphael-Greenfield, E. (2011). Assessing executive and community functioning among homeless persons with substance use disorders using the executive functional performance test. *Occupational Therapy International, 19*, 135-143. doi: 10.1002/oti.1328 ● VanLeit, B., Starrett, R., & Crowe, T. K. (2006). Occupational concerns of women who are homeless and have children: An occupational justice critique. Hawthorne Press, Inc. doi: 10.1300/j003v20n03_04
Objectives:	1. Clients in the group will complete a flow chart of their own finances for one hypothetical month 2. Clients will brainstorm money management strategies 4. Clients will verbally report an understanding of healthy financial management strategies -Saving money per month -Having emergency money available as needed

Amount of Time Needed:	45-60 minutes ● 10 minutes for introduction ● 25 minutes for money flowsheet task ● 10-20 minutes for discussion and understanding money management
Person:	Individuals new to LaGrave as well as individuals who have been at LaGrave will benefit from this activity. This activity is not appropriate for an individual who is not able to cognitively to understand cause-and-effect relationships that occur during budgeting.
Context:	Preferable to be done within the context of LaGrave in a community room. Small groups should be established at the beginning of the session to allow for proper time to share ideas and strategies for one another.
Task/Activity: (check all that apply)	● The task will focus on members learning how to manage their own finances during a one-month period, while also determining whether spending was responsible and share these ideas with small group members.
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Establish healthy financial management skills and knowledge to use If the client needed to restore the skills required to participate in this task you could consider: 1. Restore financial skills that were available prior to experiencing homelessness, and remediating those skills
Alter ✓	If the OT needed to alter the context to promote the client's ability to perform the task, you could consider: 1. The task can be completed either in a large or small group atmosphere, or individually with the therapist
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. The financial management spreadsheet can be verbally explained and reviewed by the therapist to the clients, if needed. The group size can be changed depending upon feedback

Prevent ✓	In order to develop circumstances to facilitate higher complexity in task performance the OT could consider: 1. Future unhealthy budgeting and management strategies can be prevented. This positively impacts independence in the future
Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider:
Introduction:	Financial management strategies are important for independent and productive living and to better prepare for the future (Nelson, Smith, Shelton & Richards, 2015). Improper financial management can lead to increased stress, loss of resources, employment and meaningful occupational engagement (VanLeit, Starrett & Crowe, 2006; Nelson, Smith, Shelton & Richards, 2015). Explain what the tasks of the session are Verbally mention and write the objectives so clients are aware of what is trying to be accomplished during the session Ask if there are any questions before beginning the session
Sharing:	1. What challenges did you identify? 2. What are some strategies to work around those challenges?
Processing:	1. How challenging was it for you to budget your money? 2. Where could you save money after looking at your own flowsheet? 3. Why is it important for you to include some money in savings each month? -What could you do with the saved up money?
Generalizing:	1. What are some simple tactics that you could use to budget your money in the future? 2. How beneficial would it be to plan out your finances for 12 months? Is this something you would like to do? 3. What are some goals that you can think of that display positive financial management skills? -Saving a select amount of money each month

	-Budgeting money for the week -Paying rent and utilities first before unnecessary items -Setting money aside in case of an emergency -Minimizing impulsive purchases
Application:	1. Do you think you would ever use something like this in the future to budget? 2. Do you feel that this was helpful? Why do you think I had you complete this activity?

Monthly Budget Flowsheet Example:

Monthly Budgeting Flowsheet	Beginning Monthly budget: $_____
Groceries:	Total Remaining:
Rent:	Total Remaining:
Clothing:	Total Remaining:
Savings:	Total Remaining:
Emergency:	Total Remaining:
Other:	Remaining:

Session II: Healthy Food Cooking Group

Purpose:	In previous written literature, those who are homeless suggest that there is a need to learn how to cook for themselves and/or others (Raphael-Greenfield, 2012). It is important for individuals of low socioeconomic groups to become aware of the importance of eating healthy foods like fruits and vegetables while cooking meals to promote increased health management (Garcia, Reardon, McDonald & Vargas-Garcia, 2016). Choosing options that are budget-friendly will help to make healthy eating a possibility. Educating the population about options including: frozen or canned fruits and vegetables and educating them about the importance of reading food labels will promote overall health.
Evidence Based Rationale & Source:	● Garcia, A. L., Reardon, R., McDonald, M., & Vargas-Garcia, E. J. (2016). Community interventions to improve cooking skills and their effects on confidence and eating behavior ● Raphael-Greenfield, E. (2011). Assessing executive and community functioning among homeless persons with substance use disorders using the executive functional performance test. *Occupational Therapy International, 19,* 135-143. doi: 10.1002/oti.1328
Objectives:	1. Clients will prepare a cold dish meal while working with others in the group 2. Clients will state one reason why eating healthy foods, like fruits and vegetables, can be beneficial to their overall health 3. Clients will be able to share about their personal experiences while making the cold dish meal with other individuals in the group - Promoting a sense of comfortability and community through social interaction 4. The therapist will assess each client's safety awareness, social skills and ability to demonstrate a skill taught to them.
Amount of Time Needed:	45 minutes ● 15 minutes for education and demonstration ● 20 minutes to make meal ● 10 minutes for group discussion

Person:	An individual who is new to or has resided at LaGrave for any amount of time will benefit from this intervention. Clients who wish to improve their knowledge and performance while cooking will also benefit.
Context:	Activity can be completed at LaGrave within one of two kitchenette set-ups in the community area of the facility.
Task/Activity: (check all that apply)	• The task will focus on teaching the group members about the health benefits associated with eating nutritious foods. Residents can learn about food assistance programs available to them that can help aid in their access to these items, as well. By working as a group, the members will feel like they all contributed to the meal that they will eat together.
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Have him/her learn how to make a cold meal by watching the therapist's demonstration If the client needed to restore the skills required to participate in this task you could consider: 1. Changing their current preparation from unhealthy to healthier meals after learning about the associated benefit 2. Pairing group members to an individual task within the cooking session that they used to do in the past (ex. cutting vegetables, mixing ingredients, using spices)
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. The session can be completed as a large group, smaller groups, or one-on-one with the therapist. The context could change, as well, varying from a community room to an individual's apartment
Prevent ✓	In order to develop circumstances to facilitate higher complexity in task performance the OT could consider: 1. Teaching group members about healthier food choices can positively influence their overall health

	2. Increased health will reduce or prevent the risk of illness and disease
Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider: 1. Healthy meals can be implemented into the client's daily life and this represents the creation of a healthy lifestyle
Health Promotion ✓	If the OT were to focus on health promoting components of the session they could consider: 1. Promoting healthy food choices could create opportunities for further health promotion including: exercising and going to the doctor for routine medical exams
Introduction:	Multiple factors can associate with poor diet including: occupational deprivation, low income and education levels (Garcia et al., 2016). It is important to be aware of the benefits of eating high nutritious food for both the body and mind Explain what the tasks of the session are Using visual aids and verbally mention the objectives so the client is aware of what is trying to be accomplished during the session Ask if there are any questions before beginning the session
Sharing:	1. What was your favorite part of the session? 2. How do you think eating healthy foods would impact your life?
Processing:	1. How did you feel as you were creating this meal with your peers? 2. Does cooking remind you of any positive memories that you would like to share with the group?
Generalizing:	1. What are some of the community resources you already know of that provide assistance with food?
Application:	1. How can you specifically plan to make healthy meals in the future?

Simple Cold Dish Example:
Cilantro Lime Three Bean Salad

Yields: 6 servings | Serving Size: 1/2 cup | Calories: 308 | Calories: 308 | Total Fat: 7g | Saturated Fat: 1g | Trans Fat: 0g | Cholesterol: 0mg | Sodium: 525mg | Carbohydrates: 49g | Fiber: 11g | Sugar: 11g | Protein: 14g |

Ingredients:

- 1 (15 ounce) can cannellini beans, rinsed and drained; 1 (15 ounce) can kidney beans, rinsed and drained; 1 (15 ounce) can garbanzo beans, rinsed and drained; 1/2 red onion, chopped fine
- 1/2 cup fresh cilantro chopped; 1/4 cup lime juice; 2 tablespoons honey; 2 tablespoons olive oil
- 1/2 teaspoon Kosher salt; 1 teaspoon ground cumin

Instructions

1. In a large bowl, combine all ingredients and toss well to combine. Cover and refrigerate for at least 30 minute, best if the salad is allowed to rest overnight. Toss before serving and enjoy.

*Ingredients can be substituted or eliminated to fit the budget of the individuals within the group

(Furlong, 2018)

Session III: Where am I Going?

Purpose:	Many individuals do not understand how or where to access public transportation, and this leads to decreased utilization of these services (Cronk, 2015). This activity will educate individuals at LaGrave about the Grand Forks public transportation system in order to increase community mobility. The increase of community mobility will improve access to resources within a variety of contexts (Parker & Dykema, 2013). Clients will receive a map of the Grand Forks public transportation routes and will map a route to the hospital and back as a group with the therapist.
Evidence Based Rationale & Source:	● Cronk, I. (2015). The transportation barrier. *The Atlantic*. Retrieved from: https://www.theatlantic.com/health/archive/2015/08/the-transportation-barrier/399728/ ● Parker, R. D., Dykema, S. (2013). The reality of homeless mobility and implications for improving care. *Journal of Community Health, 38*(4), 685-9. doi: 10.1007/s10900-013-9664-2. ● VanLeit, B., Starrett, R., & Crowe, T. K. (2006). Occupational concerns of women who are homeless and have children: An occupational justice critique. Hawthorne Press, Inc. doi: 10.1300/j003v20n03_04
Objectives:	1. Clients will be able to comprehend the public transportation map to identify bus stops near LaGrave 2. Clients will be able to understand the process of accessing public transportation. -What is required as a prerequisite (ex. bus pass/money, ID, route)
Amount of Time Needed:	45 - 60 minutes ● 8-10 minutes for introduction ● 20-30 minutes for map route planning task ● 15-20 minutes for discussion
Person:	Individuals new to LaGrave as well as individuals who have been at LaGrave will benefit from this activity. This activity is not appropriate for an individual who is not able to engage in higher level cognitive functioning with planning and sequencing.

	Individuals should be able to organize and judge tasks to accomplish goals.
Context:	Preferable to be done within the context of LaGrave. A large conference room for group intervention. Small groups could be set up in advance to allow for the sharing of ideas and suggestions. This activity can also be done within the community at a later time. Planning the bus ride and experiencing the actual task can be done separately.
Task/Activity: (check all that apply)	The task in this intervention is planning a bus route from LaGrave to Altru Hospital in Grand Forks, and returning to LaGrave ● Clients will need access to a map of public transportation, which is free to print from online, or available in the community ● Therapists will need to create a scenario in which a client has to be at a hospital on a certain date, at a certain time ● This activity will judge a client's ability to plan and initiate ideas. Higher functioning clients who have understanding of the public transportations system can be permitted to assist other residents, and promote a sense of community and social interaction
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Introducing the client to the map of public transportation and explaining how to read it to plan a route 2. Pairing the individual with someone who is familiar with the transportation system so they can work together to establish a route If the client needed to restore the skills required to participate in this task you could consider: 1. Discussing their previous experiences while using public transportation 2. Assisting in answering any questions that arose from previous experiences that the individual did not understand
Alter ✓	If the OT needed to alter the context to promote the client's ability to perform the task, you could consider: 1. Complete the task in a small group or one-on-one with the therapist to meet the needs of the client 2. The session can be completed within a community area or apartment of LaGrave to promote one's abilities

Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider: 1. A new opportunity of utilizing public transportation for individuals who are homeless. Allowing them transportation options that they may have not utilized before.
Introduction:	Public transportation improves a person's ability to perform community mobility, as well as access resources (Cronk, 2013). Many people do not know how to access public transportation or what they to utilize before using public transportation (Cronk, 2013, Parker & Dykema, 2013). Explain what the tasks of the session are Write and verbally mention the objectives so the clients are aware of what is trying to be accomplished during the session Ask if there are any questions before beginning the task
Sharing:	1. What route(s) did you select to get to Altru Hospital on time? 2. Did anyone find this map confusing? If so, what was most confusing for you?
Processing:	1. What was the most challenging part of this activity? 2. How many of you had a hard time planning the route? -*Sequencing and planning note: if clients had problems and with this step, executive functioning may need to be further assessed
Generalizing:	1. How confident do you feel about riding the bus at least one time this week? 2. How would you all feel if you had to do this by yourself, tomorrow? -Would you ask for help? Who would you ask to help?
Application:	1. What benefits could you utilize by learning the bus route? 2. How could you apply this to other things you need or want to do?

Unit III:

Leisure:
Session I: Art Self-Expression
Session II: What Interests Me?

This unit was created to address the needs of the population that are classified under the occupation of leisure within the OTPF. Specifically, one art task and one interest indicator activity were selected for this unit, totaling in two sessions. Social participation is also addressed throughout the unit implicitly during group interactions.

Session I: Art Self-Expression

Purpose:	Individuals who are homeless have been found to benefit from self-expression activities and exploring leisure activities (Thomas, Gray, McGinty & Elringer, 2011). Individuals all have a unique story to tell and they all have different way to express themselves. Through this art drawing activity, individuals can express how they are feeling inside and what stories they have to tell to assist in improving mental well-being. Art will allow individuals to be creative and demonstrate who they are, while also providing engagement in a meaningful occupation. Art will allow them to explore their identity within LaGrave and process through their feelings since leaving homelessness. Literature in the past has shown effectiveness when individuals were given the opportunity to display their art work (Thomas, Gray, McGinty & Elringer, 2011). This art creation from the session can be kept by the individual as a personal reminder of their journey or can be placed on display within the community areas of LaGrave, increasing one's sense of belonging within the facility.
Evidence Based Rationale & Source:	● Thomas, Y., Gray, M., McGinty, S., Elringer, S. (2011). Homeless adults engagement in art: First steps towards identify, recovery and social inclusion. *Australian Occupational Therapy Journal*, 58, 429-436. doi:10.1111/j.1440-1630.2011.00977x
Objectives:	1. Clients will be able to identify art as a possible coping skill a. Identify how self-expression through art can be used positively 2. Provide an opportunity for clients to display and discuss their art work piece to the group while explaining their story a. Provide a sense of community and comfortability
Amount of Time Needed:	60-90 minutes ● 10 minutes for set-up and introduction ● 30-40 minutes for self-expression art ● 10-20 minutes for discussion and display of the product
Person:	Anyone who is a resident at LaGrave, new or old could participate in this session. Individuals who are interested and want to explore an art creation task will be especially be interested in this session. The session may be adapted for individual who has disabilities and displays difficulties while drawing.

Context:	Preferably, this session will be completed within the small conference room at LaGrave. Additional measures should be taken to ensure privacy and confidentiality within the space during the activity, as it may be emotional for some clients.
Task/Activity: (check all that apply)	• The task will focus on the individual's unique creation of an artwork piece explaining their life journey and experiences prior to and since moving to LaGrave. This activity will allow for clients to share their drawings and feelings which will assist in understanding one another better
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Asking the client to draw how they currently view their life compared to how they did prior to having stable housing 2. Explaining the value of using healthy coping skills, like drawing, to express oneself If the client needed to restore the skills required to participate in this task you could consider: 1. Use other art supplies available at the facility that could be more familiar or meaningful to the client (ex. paint, clay)
Alter ✓	If the OT needed to alter the context to promote the clients ability to perform the task, you could consider: 1. This activity can be completed in a one-on-one session if the client is not comfortable sharing their story with the group 2. Each client can complete the activity and share within their own apartment to promote comfortability
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. Setting boundaries for the entire group to ensure that individuals who have decreased abilities are treated fairly
Prevent ✓	In order to develop circumstances to facilitate higher complexity in task performance the OT could consider: 1. Exposing residents to healthy coping strategies can decrease injury, loss of relationships and occupational deprivation

Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider: 1. Exploration of new coping skills and means of expression to allow individuals who are homeless to identify themselves. Creating something that others can see, to display that they are more than just an individual who is homeless and they have their own story.
Introduction:	According to Thomas et al., (2011) self-expression through art is a way for people to deal with their emotions and no two people have the same story. Through self-expression activities, the client has the opportunity to show others what they are dealing with and who they are through a picture. Each person is the expert of themselves and this can be seen through artwork (Thomas et al., 2011). Individuals are able to use the art supplies available at LaGrave to complete the activity. Explain the tasks of the session Write and verbally mention the objectives of the sessions so the clients are aware of what the session is trying to accomplish Ask if there are any questions before beginning the session
Sharing:	1. What was your favorite part about the drawing session? 2. What did you not like about the drawing session?
Processing:	1. How did you feel when you were drawing your life journey? 2. How did you cope with those feelings? Was drawing a comfort for you at the time?
Generalizing:	1. How can art be used as a form of coping? Could this be used for more than just a leisure activity? 2. What are other forms of coping that you currently use or have heard about? -Journaling, crafts, etc.
Application:	1. How could you use this activity or art in your everyday life? 2. What supplies do you need to continue using art as a healthy leisure activity while at LaGrave?

Session II: What Interests Me?

Purpose:	Individuals who are homeless often have limited opportunity for leisure participation present in their lives (Thomas et al., 2011). Individuals often lack participation in this area of occupation due to fixation on other aspects of life such as securing housing, employment and safety. Through completing the modified interest checklist as an intervention, individuals are able to share and identify leisure activities in which they have interest (Klyczek, Bauer-Yox & Fiedler, 1997). In the activity itself, the therapist and group individuals can identify leisure occupations that they can participate in to restore leisure in their lives. The activity will allow for leisure activity identification that can be built upon at a later time. Individuals will be able to share interests together to assist in identification of similar interests.
Evidence Based Rationale & Source:	● Nilsson I, & Fisher A. (2006). Evaluating leisure activities in the oldest old. *Scandinavian Journal of Occupational Therapy*, *13*(1), 31–37. ● Klyczek, J. P., Bauer-Yox, N., & Fiedler, R. C. (1997). The interest checklist: a factor analysis. A*merican Journal of Occupational Therapy, 51*, 815-823. ● Thomas, Y., Gray, M., McGinty, S., Elringer, S. (2011). Homeless adults engagement in art: First step towards identify, recovery and social inclusion. *Australian Occupational Therapy Journal,* 429-436(58). doi:10.1111/j.1440-1630.2011.00977.x
Objectives:	1. Clients will be able to complete the modified interest checklist and identify at least two leisure interests 2. Clients will be able to share at least one interest with the group and discuss why it is an interest to them 3. Clients will be to participate in a group environment while sharing common interests with others a. Develop a sense of community within LaGrave
Amount of Time Needed:	60 minutes ● 10 minutes for introduction ● 20-30 minutes for completion of checklist ● 20 minutes for discussion
Person:	This activity is designed for an individual who is new to LaGrave, or that has been a resident. Individuals who do not have adequate

	leisure participation in their lives will also benefit from the session.
Context:	Done within a large community room of LaGrave that has adequate space for all individuals. Clients' chronological age and life development stage should be considered during the activity to determine which leisure participation events are realistic.
Task/Activity: (check all that apply)	• The focus of the task will be identifying leisure activities that the group members may have interest in. By identifying leisure interests, the individuals could begin to engage in these occupations and improve current occupational deprivation
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Educating the client on the Modified Interest Checklist and the purpose of determining personalized potential leisure interests If the client needed to restore the skills required to participate in this task you could consider: 1. Asking the client to suggest leisure interests that they currently engage in or interests that they had prior to being homeless
Alter ✓	If the OT needed to alter the context to promote the clients ability to perform the task, you could consider: 1. This activity can be done either individually or group based depending on the needs of the client
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. The therapist could read aloud the questions on the Modified Interest Checklist to ensure comprehension of the client 2. The Modified Interest Checklist could be completed in an apartment to decrease distraction
Prevent ✓	In order to develop circumstances to facilitate higher complexity in task performance the OT could consider:

	1. Leisure activities provides a sense of identity and healthy coping for all individuals. 2. Finding leisure activities of interest to aid in coping and increased quality of life
Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider: 1. Individuals who are homeless often do not have the presence of leisure in their lives. This activity will create a list of interests, or at least get an individual starting to think about leisure interests.
Introduction:	Leisure consists of taking time for oneself in order to relax and explore new opportunities (AOTA, 2014). Leisure tasks allow one to take their mind off everyday stressors by decompressing. During the duration of homelessness, leisure activities are rarely participated in because decreased occupation engagement (VanLeit, Starrett & Crowe, 2006; Thomas, Grey & McGinty, 2017). Explain what the tasks of the session are Write and verbally share the objectives with the clients so that they understand the purpose of the session Ask if there are any questions before beginning
Sharing:	1. How do you think the session went? 2. Which component of the session did you enjoy the most? Why? 3. Which components of the session did you dislike? Why?
Processing:	1. How did you react to your selected interests from the Modified Interest Checklist? 2. Which, if any, interests do you think you would enjoy? 3. How did you feel while completing this session?
Generalizing:	1. Where can you complete you selected interests at LaGrave? In the community? 2. Why is it important to learn about your interests?

	3. Where can you incorporate these interests into your everyday life?
Application:	1. Who in this group had a similar interest as you? Could you do this activity together in the future?

The Modified Interest Checklist can be located at the following website, free of charge: https://www.moho.uic.edu/productDetails.aspx?aid=38

Unit IV:

Work:

Session I: What Skills Do I Have?
Session II: Where Do I Want to Be for Employment?
Session III: Where Do I Want to Be for Volunteering?

Within Unit IV, three intervention sessions were created to address the occupation of work in the OTPF. The three interventions address resume building and employment/volunteer exploration. Sessions two and three of this unit were combined into one chart, due to having only one difference, whether the client will be working for employment or volunteering. A supplemental handout for this area of occupation was used to guide intervention and has been added to the appendix (Healthrecovery.org, n.d.). Social participation is included within all sessions as group member's work together and share ideas and suggestions related to work.

Session I: What Skills Do I Have?	
Purpose:	One of the greatest needs of individuals who are homeless, as mentioned in the literature are pre-vocational skills (Pickett-Schenk, et al., 2002; Thomas, Gray, & McGinty, 2017; VanLeit, Starrett & Crowe, 2006). Individuals who are homeless possess pre-vocational skills, but do not necessarily know how to use these skills effectively (VanLeit, Starrett & Crowe, 2006). This activity assists in mending this disconnect by identifying skills of each individual client by creating a resume for future employment/volunteering. ● Through creation of a resume, individuals can collaborate with one another to identify what skills are important to consider, what past experiences are relevant and organization of past experiences. ● Through the creation of the resume, individuals will have a better understanding of what skills they possess (Hoven, Ford, Willmot, Hagen & Siegrist, 2016; Joseph, 2018), and how they can market their skills for employment (Pickett-Schenk et al., 2002; VanLeit, Starrett & Crowe, 2006). ● Individuals will be able to collaborate and share ideas with other group members to promote social interaction and to identify what skills would be relevant for a resume. The therapist will also be able to assist with ideas for contents of the resumes (Healthrecovery.org, n.d.). Each client's resume should be reviewed by the therapist to ensure quality (Healthrecovery.org, n.d.).
Evidence Based Rationale & Source:	● Hoven, H., Ford, R., Willmot, A., Hagan, S., & Siegrist, J. (2016). Job coaching and success in Gaining and sustaining employment among homeless people. *Research on Social Work Practice, 26*(6), 668-674. Doi: 10.1177/1049731514562285 ● Pickett-Schenk, S. A., Cook, J., Grey, D., Banghart, M., Rosenheck, R. A., Randolph, F. (2002). Employment histories of homeless persons with mental illness. *Community Mental Health Journal, 38(*3), 199-211. ● Thomas, Y., Gray, M. A., McGinty, S. (2017). The occupational wellbeing of people experiencing homelessness. *Journal of Occupational Science, 24*(2), 181-192. doi: 10.1080/14427591.2017.1301828

	● Braveman, B. & Page, J. (2012). *Work - promoting participation and productivity through occupational therapy*. Philadelphia: FA Davis Company ● VanLeit, B., Starrett, R., & Crowe, T. K. (2006). Occupational concerns of women who are homeless and have children: An occupational justice critique. Hawthorne Press, Inc. doi: 10.1300/j003v20n03_04 ● Healthrecovery.org (n.d.). *Prevocational Handbook*. Retrieved from: http://www.healthrecovery.org/images/products/6_inside.pdf ● Joseph, S. V. (2018). 4 resume tips you've probably never heard before. *Forbes*. Retrieved from: https://www.forbes.com/sites/shelcyvjoseph/2018/05/16/4-resume-tips-youve-probably-never-heard-before/#4c9b3d511920
Objectives:	1. Clients will be able to identify relevant skills necessary for employment 2. Clients will share collaboratively to identify what skills are relevant on a resume 3. Clients will successfully draft a copy of their own personal resume for future employment or volunteering
Amount of Time Needed:	60 minutes ● 10 minutes for introduction and set-up ● 30-40 minutes for drafting of resume and skill identification. Residents do not need to complete the resume, but should feel comfortable with the concept and what they should include ● 10-20 minutes for discussion about activity
Person:	This activity should only be done if a client is appropriate for employment or volunteering. A client should have the appropriate cognition and functional ability to participate in these respective occupations and while creating a resume. Completion of this task if the client is not appropriate, would not be beneficial or purposeful and could be overwhelming.
Context:	This activity can be completed in a large community room of LaGrave that has adequate space for all individuals. Clients should be considered regarding chronological age and life development stage to consider which work opportunities would be appropriate.

Task/Activity: (check all that apply)	• The task will focus on the client exploring their pre-vocational skills and creating a resume to use for employment or volunteering opportunities. Clients will be provided with paper and pencils to draft up ideas and write down their unique skills, abilities and experiences that are relevant for a resume. Collaboration is encouraged during this task. Important notes about relevance of past experiences, action verbs with skills and education levels should be expressed. Clients will have the opportunity to translate their paper to a Word document and print it, if resources available, at a later time.
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. The establishment of current pre-vocational skills will boost the client's confidence 2. The establishment of the concept of work could improve one's sense of belonging and contribution to society 3. Identifying what skills are needed for job interests 4. Identifying where/how to gain these skills If the client needed to restore the skills required to participate in this task you could consider: 1. Asking the client what they did for employment or volunteering in the past 2. Role play a typical exchange in a previous work scenario to identify the client's pre-vocational skills
Alter ✓	If the OT needed to alter the context to promote the clients ability to perform the task, you could consider: 1. This activity can be done either individually or as a group. Group sessions will be most beneficial for social interaction and collaboration of ideas.
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. Touring a potential place of employment to learn about the natural environment 2. Going to job services to explore potential areas of interest 3. Contacting vocational rehabilitation services to explore more opportunities

Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider: 1. Develop a product that can be used to seek employment in the future
Introduction:	Individuals who have been homeless may or may not have had opportunities to work. Addressing this need is important to stop the cycle of chronic homelessness. Identifying pre-vocational skills that an individual possesses and creating a resume to display those skills is helpful. A current and up to date resume is an important factor in gaining employment (Joseph, 2018). Without a resume, the odds of gaining employment after application are slim to none. A resume will help organize and present to an employer what skills you have and market them (Joseph, 2018). Explain the tasks of the session to the clients Write and verbalize the objectives of the session so that the clients understand what will be accomplished at the conclusion Ask if there are any questions before starting the session
Sharing:	1. What are some of the pre-vocational skills you identified? 2. What was your favorite past experience that you put on your resume?
Processing:	1. How did creating this resume make you feel? -Proud? Frustrated? Surprised? 2. How does it feel to think about your pre-vocational skills? 3. What about your feelings while you read your accomplishments listed on your resume?
Generalizing:	1. What employment or volunteer opportunities could you participate in after looking at your skills and experience? 2. How can you use this activity in the future besides finding work opportunities? -Review of accomplishments, applying for assistance, etc
Application:	1. Will this resume be able to help you market your skills?

	2. Will you be able to use this resume to apply for work/volunteer? 3. Do you feel competent enough seek employment?

Session II & III: Where do I Want to Be for Employment/Volunteering?

Purpose:	In order to implement employment or volunteer opportunities into the client's life, it is important to determine the client's personal interests, values and skills (Pickett-Schenk, Cook, Grey, Banghart, Rosenheck & Randolph, 2002). It is important to remember that individuals who have experienced chronic homelessness often experience mental health illnesses (Fichter & Quadflieg, 2006). Mental health illnesses can negatively impact an individual's ability to remain employed, as well (LaMontagne, Martin, Page, Reavley, Noblet, Milner, Keegel & Smith, 2014). ● Clients will explore potential interests of jobs/volunteer opportunities through the ONET Interest Profile, which is a free online resource. ● After determining possible fields to work/volunteer in, the group will begin to individually search for opportunities within the Grand Forks area that match their own unique interests. ● This intervention will provide clients with tools to assess their own interests and provide them with resources to seek out employment/volunteer opportunities. ● By implementing this treatment session, it is expected that members will be more likely to engage in meaningful employment/volunteering.
Evidence Based Rationale & Source:	● LaMontagne, A. D., Martin, A., Page, K. M., Reavley, N. J., Noblet, A. J., Milner, A. J., Keegel, T. & Smith, P. M. (2014). Workplace mental health: Developing an integrated intervention approach, *BMC Psychiatry, 14*(131), 1-11. ● Pickett-Schenk, S. A., Cook, J., Grey, D., Banghart, M., Rosenheck, R. A., Randolph, F. (2002). Employment histories of homeless persons with mental illness. *Community Mental Health Journal, 38(*3), 199-211. ● Fichter, M. M., & Quadflieg, N. (2006). Intervention effects of supplying homeless individuals with permanent housing: A prospective study. *Acta Psychiatrica Scandinavica*, *113*(49), 36-40. doi: 10.111/j.1600-0447
Objectives:	1. Clients will explore potential employment/volunteer interests through the ONET interest profile

	2. Clients will explore employment/volunteer opportunities through a variety of media sources 3. Clients will identify one area of employment/volunteer that they would like to pursue within the community
Amount of Time Needed:	80 minutes ● 15 minutes for introduction and navigation to ONET ● 15 minutes to complete ONET interest profiler ● 25 minutes to browse media for work/volunteer opportunities ● 25 minutes for discussion and collaboration
Person:	This activity is designed for an individual who is new to therapy at LaGrave. Individuals should be cognitively, physical and willing to participate in work opportunities in the future.
Context:	This activity can be completed in a community space within LaGrave. The session can be completed as a large or small group, depending on the needs of the participants.
Task/Activity: (check all that apply)	● This task will focus guiding clients through possible work interests, after completing the ONET Interest Profiler. The results from ONET will be considered by the client and they will begin looking for specific employment or volunteer opportunities of interest in Grand Forks.
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Instructing the client on the purpose of using the ONET Interest Profiler and how this information can transfer to finding a meaningful work experience If the client needed to restore the skills required to participate in this task you could consider: 1. Identify what interests the client had before homelessness
Alter ✓	If the OT needed to alter the context to promote the clients ability to perform the task, you could consider: 1. The activity could be completed as a group or one-on-one with the therapist
Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider:

	1. Develop a personal inventory of interests that can be referenced in the future, with recommendations for employment areas.
Introduction:	1. How meaningful is it for you to work or volunteer? 2. Have you considered jobs that you would like to do? 3. What are some of your interests? In relation to jobs or volunteer opportunities? 4. Please explain a work experience that you participated in in the past with the group. Finding a job that matches one's interests and capabilities is often overlooked (Pickett-Schenk, 2002). Individuals who are homeless are often concerned with finding only opportunities that provided income, while personal preferences can be forgotten (Pickett-Schenk, 2002). Now that you are here at LaGrave, we will focus on the opportunity to look for work that you want to do. Explain the tasks of the session Write and verbalize the objectives so the clients understand what is expected to be learned from the session Ask if there are any questions before beginning
Sharing:	1. Please share with the group what job/volunteer opportunities you found while using the ONET interest profile. 2. What was your favorite thing about the ONET profiler? 3. What didn't you like about about the ONET profiler?
Processing:	1. Did you discover any new potential opportunities that you did not think of working in before the session? 2. How did the list of suggested work make you feel? 3. Were you surprised at the work experiences available within the community?
Generalizing:	1. When can you use this tool in the future? 2. What facilities in the community will you be able to complete your work of interest?
Application:	1. How can you use the information the information you

	learned from this session every day? 2. How will you commit to exploring employment or volunteer opportunities within the community?

Unit V:

Sleep:

Session I: Creating an Evening Sleep Routine
Session II: Progressive Muscle Relaxation

Unit V contains two intervention sessions that relate to the occupation of sleep in the OTPF. The sessions will specifically address the development of an evening routine and progressive muscle relaxation to promote increased sleep participation. The sessions will include opportunity for social participation due to assisting and sharing feedback about the interventions with others.

Session I: Creating an Evening Sleep Routine	
Purpose:	Individuals who are homeless often experience physical and mental health declines, which are associated with declined sleep habits and sleep participation (Freeston, Mavros, Richards & Fiatarone-Singh, 2017; Hui-Ling Chang, Fisher, Reitzel, Kendzor, Nguyen & Businelle, 2015). It is important to establish an evening routine to promote increased rest and sleep of these individuals, who often have increased mental and physical health issues. ● This activity will be aimed at describing the subjective experiences of each client and their experiences with sleep deprivation and perceptions on how it has affected their overall health ● The activity will use those perceptions to motivate clients to create a sleeping routine to assist with the transition to normal sleep behaviors, 6-8 hours per night ○ Normal sleep participation is associated with improved quality of life and increased physical and mental health ○ This activity will also contribute to establishing healthy routines in the area of rest and sleep
Evidence Based Rationale & Source:	● Freeston, J., Mavros, Y., Richards, J., & Fiatarone-Singh, M. (2017). Crisis accommodation is associated with increased physical activity and reduced sleep among those experiencing homelessness in an urban setting. *Journal of Science & Medicine in Sport*, *20*, e46 ● Hui-Ling Chang, Fisher, F. D., Reitzel, L. R., Kendzor, D. E., Nguyen, M. A. H., & Businelle, M. S. (2015). Subjective sleep inadequacy and self-rated health among homeless adults. *American Journal of Health Behavior*, *39*(1), 14–21
Objectives:	1. Client will be able to discuss subjective experiences of sleep patterns and perceptions of how sleep is impacting their health 2. Client will be able to verbalize the importance of healthy sleep routine and amount of required sleep 3. Client will be able to develop an evening routine to assist in proper sleep hygiene 4. Client will share ideas for evening routines to identify similar

	interests and ideas with other members in the group
Amount of Time Needed:	45-70 minutes ● 10 minutes for introduction ● 20-30 minutes for task completion ● 15-30 minutes for discussion and sleep education.
Person:	All individuals within LaGrave can benefit from this activity. New residents and current residents will especially benefit if they have trouble getting enough sleep each night.
Context:	The session will be help in a community area at LaGrave to ensure adequate room for all members to participate.
Task/Activity: (check all that apply)	● The task will include an education session about the importance proper of sleep hygiene and how it impacts the body. After the education, clients will reflect on their own sleep patterns and consider if there is room for improvement within their evening routine. Following this discussion, the clients will begin to create their own evening routine to follow each night to promote participation in sleep.
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Establish what preparations the client must complete to fall asleep 2. Determine if a checklist will help the client's task performance regarding sleep If the client needed to restore the skills required to participate in this task you could consider: 1. Having the client think about how often they used to sleep prior to homelessness, during homelessness and now at LaGrave
Alter ✓	If the OT needed to alter the context to promote the clients ability to perform the task, you could consider: 1. Adjusting the size of the group or completing the activity one-on-one with the therapist
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider:

	1. Developing this routine in the evening so the client can complete each step at each corresponding hour and in the natural environment
Prevent ✓	In order to develop circumstances to facilitate higher complexity in task performance the OT could consider: 1. Preventing improper sleeping habits from occurring and decreasing overall health 2. Allowing clients to develop healthy sleep routines that assist with health promotion and maintenance will decrease the chance of illness and disease
Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider: 1. Creation of a healthy routine for sleep to improve physical and mental health.
Introduction:	1. Who has trouble falling asleep at night? 2. Did you know that your sleep impacts your health? Poor sleep patterns, routines and habits are very highly correlated with individuals who are homeless (Thomas, Gray & McGinty, 2017). Poor sleep participation can lead to increased stress, lethargy and poor cognitive output (Freeston, Mavros, Richards & Fiatarone-Singh, 2017). This task will help identify what proper sleep hygiene is and how to develop an evening routine that can be used to help with sleep participation. The client will create a visual schedule of an evening routine that can be used to help during the transition to sleep. Explain the tasks of the session to the clients Write and verbalize objectives so the clients are aware of the purpose of the session and what is hoped to be learned Ask if there are any questions prior to beginning
Sharing:	1. How many hours do you usually sleep each night? 2. How could you benefit from getting enough sleep?
Processing:	1. What emotions did you feel as you were creating your evening routine? 2. How did you overcome any negative feelings associated with

	this activity? 3. How confident do you feel that you will be able to follow this routine? Why do you feel that way?
Generalizing:	1. Where else in your daily life can you create a routine to promote consistency? 2. How do you think following this schedule will impact you overall?
Application:	1. How can you ensure that you will continue to use your evening routine? 2. Name one way that you will remind yourself to follow the evening routine each night.

Session II: Progressive Muscle Relaxation

Purpose:	Individuals who are homeless often experience physical and mental health declines, associated with declined sleep habits and sleep participation (Freeston, Mavros, Richards & Fiatarone-Singh, 2017; Hui-Ling Chang, Fisher, Reitzel, Kendzor, Nguyen & Businelle, 2015). This activity will be targeted at sleep preparation and assisting individuals in falling asleep. The activity will specifically contain a progressive muscle relaxation exercise to be performed with group members. Individuals who are homeless often feel anxious about sleep and struggle to fall asleep. Progressive muscle relaxation will assist these individuals in preparing the body for rest. This activity can also be generalized as a coping strategy to be used when a client is feeling stressed.
Evidence Based Rationale & Source:	● Freeston, J., Mavros, Y., Richards, J., & Fiatarone-Singh, M. (2017). Crisis accommodation is associated with increased physical activity and reduced sleep among those experiencing homelessness in an urban setting. *Journal of Science & Medicine in Sport*, *20*, e46 ● Hui-Ling Chang, Fisher, F. D., Reitzel, L. R., Kendzor, D. E., Nguyen, M. A. H., & Businelle, M. S. (2015). Subjective Sleep Inadequacy and Self-rated Health among Homeless Adults. *American Journal of Health Behavior*, *39*(1), 14–21 ● Seyedi Chegeni, P., Gholami, M., Azargoon, A., Hossein Pour, A. H., Birjandi, M., & Norollahi, H. (2018). The effect of progressive muscle relaxation on the management of fatigue and quality of sleep in patients with chronic obstructive pulmonary disease: A randomized controlled clinical trial. *Complementary Therapies in Clinical Practice*, *31*, 64–70. ● Varvogli, L., Darvirl, C. (2011). Stress management techniques: evidence-based procedures that reduce stress and promote health. Health Science Journal, 5(2), 74-89.
Objectives:	1. Client will understand the importance of preparing the body for sleep 2. Client will understand the importance of proper sleep patterns for health 3. Client will participate and experience progressive muscle relaxation as a technique to ready oneself for sleep

	4. Client will discuss how progressive muscle relaxation can assist in preparing oneself for sleep and help to fall asleep
Amount of Time Needed:	60 minutes ● 15 minutes for room preparation and introduction ● 25 minutes for education and task completion ● 20 minutes for discussion
Person:	All individuals within LaGrave can benefit from this activity. Clients who would like to learn a relaxation exercise and coping strategy will also likely benefit from the session.
Context:	The session will occur in a large meeting room to ensure proper space for everyone to relax. If applicable and safe, members can sit in chairs or lay on the ground during the exercise.
Task/Activity: (check all that apply)	● The task will focus on increasing relaxation through an instructed progressive muscle relaxation exercise. Clients will be encouraged to use this exercise while preparing for sleep in the evening to promote proper sleep hygiene.
Establish/Restore ✓	If the client needed to establish the skills required to participate in this task you could consider: 1. Determining what the client currently does to fall asleep If the client needed to restore the skills required to participate in this task you could consider: 1. Asking the client if they have ever tried progressive muscle relaxation in the past
Alter ✓	If the OT needed to alter the context to promote the clients ability to perform the task, you could consider: 1. The activity can be completed as a group or one-on-one with the therapist. If completing the session individually, it is recommended that the client perform the progressive muscle relaxation within their own bed in the apartment
Adapt ✓	If the OT needed to adapt the context so the client could experience increased competence and performance, you could consider: 1. Turning down the lights and playing soft music to promote relaxation

Create ✓	(Dear OT - for create, remember to review this statement) = In order to develop circumstances to facilitate higher complexity in task performance, the OT should consider: 1. Sleep preparation activities may not be something readily known by clients, and this will allow the clients to explore a sleep preparation idea that they may not have known before
Introduction:	1. How many of you have trouble relaxing before you go to sleep? 2. Have you woken up feeling restless during the night and can't seem to fall back to sleep? Poor sleep patterns, routines and habits are very highly correlated with individuals who are homeless (Thomas, Gray & McGinty, 2017) Poor sleep participation can lead to increased stress, lethargy and poor cognitive output (Freeston, Mavros, Richards & Fiatarone-Singh, 2017). Nightmares or restless can be symptoms of poor sleeping and homelessness. Progressive muscle relaxation can help the body prepare for sleep and become less tense (Varvogli, Darvirl, 2011). Completion of this task can help you learn how to prepare for sleep, or help fall back asleep through relaxation (Varvogli, Darvirl, 2011). Explain the tasks of the session to the clients Write and verbalize the objectives so clients are informed about the goals of the session Ask if there are any questions prior to beginning the activity *If possible, dim or turn off the lights (if safe to do so) to assist in muscle relaxation and sleep preparation. The goal is not to have the clients fall asleep, but to participate in it to use in the future.
Sharing:	1. What did you think about the progressive muscle exercise? 2. What was your favorite part about the activity?
Processing:	1. How did you feel before vs. after this activity? 2. If you became more relaxed after the exercise, what parts of your body specifically felt better? Why do you think this is?
Generalizing:	1. What other times in your everyday life can you use this

	exercise? 2. What environments is this exercise not safe to do?
Application:	1. When will you try muscle relaxation next? 2. Who can remind you about progressive muscle relaxation before bed or when you are upset in the future?

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Appendix

The Pre-Vocational Handbook Contents

These materials were designed to be presented by non-vocational specialists trained by Institute for Health and Recovery Substance Abuse/Vocational staff. Descriptive materials, leader's notes and handouts are included. Chapters may be used consecutively and completely for the most effective learning experience. Depending on the needs of the client(s), however, chapters may also be used independently of one another. Chapter descriptions follow. Games for Learning can be used in any order.

Introduction: Guidelines
Guidelines for implementation of the *Handbook*, as well as sample workshop series, are included in the introduction. Issues pertaining to work, treatment and recovery are also addressed.

Chapter 1: Life Skills
This chapter includes tools that will enable a woman to better care for herself by reviewing her lifestyle and equipping her to identify and manage stress. Affirming readings are included.

Chapter 2: Career Exploration
Work values and job preference exercises contribute to goals development and personal economic planning. Clients will need support going through the goals process, as there may be women who have not previously engaged in goal-setting. Labor market trends identify promising careers. Have fun with the games and visualizations, as they offer a non-threatening approach to career brainstorming.

Chapter 3: Customer Service
Customer service is a part of just about every job and goes beyond the retail setting. Basic concepts of good customer service are introduced. Games and exercises offer experiential opportunities for the group. If possible, give clients the chance to answer the telephone, take accurate messages and transfer calls in a professional manner.

Chapter 4: Internships, Mentoring and Shadowing
You can support community service as a learning experience by formalizing the expectations and evaluations of the workplace. Enclosed are sample documents for reference in turning unpaid work into material for a resume.

Chapter 5: Resume Building
Resume descriptions, transferable skills, worksheets, formats and samples are presented here. The "Poe" resume style is especially useful for those with poor work histories. "Job Retention Proofs" are so important that they are also included in the chapter on Interviewing and Job Retention. Clients determine their transferable skills and then give examples of when and where they used these skills in their resume.

Chapter 6: Interviewing
Suggestions for dealing with difficult questions about poor work and/or criminal justice histories are included here. Interviewing tips are offered that include professional presentation and formats for interviews. The format included answers an employer's favorite question, "Why

don't you tell me a little about yourself…" Put those soft and hard skill proofs into action! Clients can practice interviewing as much as possible, using notes only as back-up.

Chapter 7: Job Search
Applications are addressed. Varieties of job search strategies are emphasized. The "Job Search Worksheet" is a great way to keep track of job leads and responses. Stress the importance of cover and follow-up letters. Play some games or schedule some stress-relievers into this job search time, which can be frustrating and demoralizing. Encourage people to practice their affirmations from the "Mentor" section of the handbook.

Chapter 8: Games for Learning
Games are all about playing, of course, but they are also about learning. They are based on the premise of "risk-taking education." Like recovery, learning (and re-entering the workforce) implies a change that can result in excitement, increased hope, insecurity and frustration. One of the objectives of "adventure education" is to help participants deal with the process of risk and the product of behavioral change.

Chapter 9: Before the Job Starts
Some helpful hints on what to do between the "getting" of a job and the actual start of the job. Preparation for the realities and challenges of the world of work are good topics for this exciting but stressful time.

Chapter 10: Job Retention
Encourage the new worker to identify where, who, when and how she will maintain her support for her recovery in this crucial time of transition. Relapse prevention is a critical component of job retention. This chapter can be placed anywhere in this curriculum. It is never too early to practice keeping the job! It is the "soft" skills that will keep a worker in a job. Case studies and charades are available for some "real life" challenges that will face the new workers.

Chapter 11: Budgeting and Taxes
Tax strategies for low-income families can save women a significant amount of money. A paycheck sounds like a lot of money until it flies away too quickly. People often spend more money when their income increases, only to discover that they don't have enough money to pay the bills. A preview of the net income will enable the new employee to create a budget – and keep those personal economic plan goals in mind! Consumer credit issues are also included in this chapter.

Chapter 12: Community Resources
Regional directories for child care, community action agencies, welfare to work programs and Career Centers are included in this section. Information is also provided about the Massachusetts Rehabilitation Commission.

Introduction to the Pre-Vocational Handbook Institute for Health and Recovery

A Pre-Vocational Handbook was developed specifically to assist the gradual integration of work-related skills and tasks into the substance abuse treatment setting as clients prepare for eventual economic self-sufficiency. It presents a basic overview of concepts and tasks necessary for clients who are preparing to re-enter the world of work. Many materials were designed specifically for clients with poor work histories, though persons with significant work experience will also find useful resources herein.

These materials were also designed to be presented by non-vocational specialists. With training by Institute for Health and Recovery Vocational staff, substance abuse treatment providers will have the necessary information for facilitating the implementation of this handbook.

Work can provide a sense of well-being, self-esteem and security to persons at certain phases of treatment. Research from CASAWorks with Families of Columbia University reveals that "economic stability and full-time employment are among the primary factors associated with the successful rehabilitation of substance abusers." In fact, "substance abuse treatment, employment, training and welfare to work theory and practice converge."1 All of these programs rely on structures and organizations that require "soft skills" such as dependability, problem-solving, perseverance, excellent attendance, initiative and the ability to follow directions.

There will be clients who, for various reasons, will not be able to work upon completion of treatment. Yet most clients will need to gain employment at some point in their recovery. Indeed, vocational and economic stability can be a strong element in relapse prevention. As accessibility of government-funded vocational training programs diminishes for women with school-age children, substance abuse treatment programs are recognizing the need to help prepare their clients for the world of work. Of necessity and in spite of time constraints, more and more substance abuse treatment programs are incorporating vocational counseling and resources into their programs.

This handbook will provide residential and outpatient substance abuse treatment providers with some of the tools necessary to help clients weave work and recovery into a life filled with hope and promise.

*1 FamilyWorks: Substance Abuse Treatment and Welfare Reform, Public Welfare (Winter, 1998)

Work and the Stigma of Substance Abuse

"According to a national survey by the Hazelden Foundation, the majority of Americans say they accept alcoholism as a disease (79%); yet when presented with a practical situation, many people reveal a bias against the recovering alcoholic or addict. The telephone survey of 1,500 adults across the country found that if the respondents had to choose between two equally qualified job candidates – one who's a recovering alcoholic and one who never needed treatment for alcoholism – almost half (47%) said they would hire the one who never needed treatment. When

respondents were also asked to choose between two job candidates – one who's a recovering drug addict and one who never needed treatment for drug addiction, 60% said they would hire the one who never needed treatment."1

This handbook is designed to be used in substance abuse treatment programs and includes materials that are directly relevant to persons in addictions treatment. Yet the handbook also contains a significant amount of material that is not specifically geared to persons in treatment, but is applicable to any jobseeker. It might be asked, then, "Why should substance abuse treatment professionals use a pre-vocational curriculum if every worksheet does not refer directly to substance abuse?"

Employment plays a critical role in helping women move away from addiction, poverty and abuse, but such a role is predicated on overcoming the stigma attached to addiction and treatment. What is true for recovering persons has been true for other populations over the years: they need to work harder to find employment and then work harder to prove that they can contribute to the well-being of the workplace.

This handbook is meant to help persons in addictions treatment to be as well-prepared as possible for re-entering the workplace. The better prepared they are on their resume and in their interview, the more they will impress the business community who still stigmatizes alcoholics and addicts. The better their life coping skills are, the better their job coping and job keeping skills will be.

The challenge is to educate the business community that hiring recovering persons can be a good business practice. Such persons have stopped using their addictive substances, embraced treatment programs, changed their lifestyles and are likely to show many of the job retention skills mentioned throughout this handbook. Since over 77% of illicit drug abusers are employed full-time, hiring persons who have been already been in treatment can be a safer business choice than general hiring. Recovering people do not need special privileges, they need fair and equal opportunities. Please note the following materials about the effects of treatment on the workplace.

*1 Retrieved from the Hazelden website on the World Wide Web at http://www.hazelden.org, January, 2000.

The Effect of Treatment on the Workplace

Treatment is hope. Treatment works. Treatment is work. Work is treatment. Treatment and work keeps families together. Work and treatment help businesses thrive.

After 1 year in treatment:1
- ♦ 75% less criminal activities
- ♦ 19% more employment
- ♦ 50% fewer medical visits
- ♦ 28% fewer mental health visits

♦ 42% less homelessness
♦ 34-56% less high risk social behavior

In a study in Massachusetts, employment rates after treatment rose 400%.2

In a study in Ohio, treatment affected the workplace by decreases in:3
♦ absenteeism by 89%
♦ tardiness by 92%
♦ on-the-job injuries by 57%

Earnings increase through treatment participation:
♦ In a study in Kansas, monthly earnings for those who complete training increased to 33% higher than earnings before treatment 4
♦ In a study in Washington State, AFDC clients completing intensive inpatient treatment were 64% more likely to have earned income than a comparison group 5

Substance Abuse decreases with treatment: 6
After 5-16 months of treatment,
♦ illicit drug use decreased by about 50%
♦ alcohol abuse decreased by over 67%

Substance abuse treatment improves job training effectiveness.7

Employment helps moderate the occurrence and severity of relapse to addiction.8

*1 Presentation by George Gilbert of the Center for Substance Abuse Treatment, (1999).
*2 Annual Report, Massachusetts Department of Public Health/Bureau of Substance Abuse Services (1999).
*3 Cost Effectiveness System to Measure Drug Abuse and Alcohol Treatment Outcomes, Ohio Department of Alcohol & Drug Addiction Services, (1999).
*4 Implementing Welfare Reform: Solutions to the Substance Abuse Problem, Child and Family Futures, (February, 1997).
*5 The Impact of Substance Abuse Treatment on Employment Outcomes Among Assistance to Families with Dependent Children (AFDC), Technical Assistance Publication Series 25, Substance Abuse & Mental Health Services Administration/Center for Substance Abuse Treatment (2001)
*6 Final Report: Center for Substance Abuse Treatment, Substance Abuse & Mental Health Services Administration, (1997).
*7 Rector, R. Drug treatment improves job training effectiveness. Intellectual Ammunition. (September/October 1997).
*8 Platt, J.J. Vocational rehabilitation of drug abusers. Psychological Bulletin (1995).

Predicting Success on the Job

Succeeding on the job can mean various things: maintaining recovery, keeping a job, adequately completing job tasks, showing basic life skills management, having good attendance, obtaining benefits, wage increases and promotions as well as increased family stability. It can also mean "serial employment" or "job hopping," leaving one job to obtain another. Maintaining employment may be a more realistic and practical goal than keeping one particular job for an extended period of time.

While success on the job is very difficult to project, there are tools that can be used to indicate a degree of likelihood that a person has the characteristics, commitment and experience to obtain and retain employment. Your clinical evaluation of the client's recovery is an essential factor in determining probable success. Some tools that can contribute to the probability of client success on the job may be discovered by having a client complete the following worksheets. Further information about each category may be found in related chapters.

Life Skills

The more well-equipped a client is to handle job- and family- related challenges, changes and stressors, the greater the likelihood that she will succeed on the job. The following worksheets will provide the client with personal resources for stress-management.

- ♦ Lifestyle Survey
- ♦ Tolerance Survey
- ♦ Stress Management

Reading and Math Skills

There is no specific tool in this handbook to assess these grade levels. Generally, those people who have higher reading and math skills are more likely to obtain and retain employment than those with lower level skills. The local Career Center/Adult Basic Education professional can assess client educational levels. Persons with limited English should work on English as a second language as soon as possible to enhance their employability.

Participation in Substance Abuse Treatment

The more a client engages in treatment activities, including employment-related tasks, the likelier it is that she will more actively engage in employment activities.

Games for Learning

Participating in games can be uncomfortable or challenging to people. If a client can trust the game leader and risk doing something new, the chances are greater that a client can risk entering a new work situation.

Resume Building:

Persons with significant work history are more likely than those with poor work histories to obtain and retain employment. Pertinent information may be discovered using the following worksheets.

♦ Vocational History: reviewing number and duration of jobs, reasons for leaving job as well as attitudes toward supervisors will give you an idea of the client's durability in the workplace. A

suggested approach to a difficult job experience is, “What did you learn about yourself at that job? Is there something that you would do differently if you could?”
♦ Job Retention Proofs: does the client understand the need for excellent attendance, flexibility, etc.? Can the client give examples from this list with a leader’s help?

Key factors linked to sustaining employment
♦ Finding jobs at relatively high wages
♦ Working steadily, initially
♦ Using formal childcare arrangements

Key factors linked to advancing to better jobs
♦ Staying in a good job
♦ Changing jobs
♦ Find jobs at relatively high wages
♦ Working in certain occupations, i.e., not sales
♦ Developing basic skill levels and obtaining education beyond high school

(Healthrecovery.org, n.d.).

CHAPTER V

Summary

Project Overview

The purpose of the *Well-being and Health Promotion Template* was to establish an Occupational Therapy template that can be used by the occupational therapists of Altru Health System. The template utilizes a theory driven, evidence-based process for evaluation through intervention implementation. Interventions were organized in the product with consideration to the areas of occupation presented in the Occupational Therapy Practice Framework (OTPF). Through the use of this template, occupational therapists at LaGrave on First can provide meaningful intervention that is guided by occupational therapy theory.

Limitations

1. There is limited current research regarding those who are homeless and occupational therapy's role working with this population.
2. Unknown ability for generalizability
3. Lack of data supporting the implementation of the product

The lack of present literature within occupational therapy is a limitation, and required the use of peer-reviewed literature sources from other professional disciplines. These additional resources were evaluated on credibility and relation to the goals of occupational therapy practice while working with the homeless population.

Implementation Proposal

To implement the product into practice, an occupational therapist from Altru Health Systems can use this template in addition to other preferred interventions at LaGrave. This scholarly project provides a template that can be used and adapted as needed by the occupational therapy staff. The template may also be adapted and altered at other homeless facilities with occupational therapy services, due to the template being tentative.

Conclusion

This scholarly project is unique in that it is the first intervention template for occupational therapy services at LaGrave on First. It is the hope of the authors that the product will assist in providing quality occupational therapy intervention to residents. By doing this, it is hoped that residents will have an increased sense of well-being and health promotion in order to increase occupational participation while gaining control of their lives once again.

Recommendations

1. The template should be used in conjunction with other occupational therapy intervention to maximize treatment efforts of the staff and benefits of the residents.
2. An independent study should be completed to assess the quality and effectiveness of the intervention template.

The implementation of this template in current practice will assist in delivery of services by being up-to-date and evidence-based. An independent study will also assist the template to increase its effectiveness while working with individuals who are homeless at LaGrave on First. The overall use and recommendations of this scholarly project are intended to benefit current occupational therapy practice and can be used to improve patient care.

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Appendix